Idaho's Comprehensive Plan for HIV Prevention

2004-2006

2005 Update

Developed by the Idaho HIV Care and Prevention Council
in partnership with the Idaho STD/AIDS Program
of the Idaho Department of Health and Welfare

IDAHO STD/AIDS PROGRAM

TABLE OF CONTENTS

The Idaho HIV Care and Prevention Council

Idaho has one statewide community planning group: the Idaho HIV Care and Prevention Council (ICPC). Since January 2003, the ICPC has functioned as a planning group for both HIV prevention and care services. This collaboration has proven to be valuable in the development of prevention services for persons living with HIV/AIDS.

Purpose and Function

The purpose of the ICPC is to strengthen Idaho's HIV care and prevention programs. The ICPC develops a comprehensive HIV prevention plan that is evidence-based, relevant to Idaho's populations at risk of infection, and based on meaningful community input.

The ICPC uses a "community planning" process to accomplish its work. Members work in partnership with the Idaho STD/AIDS Program to assess prevention and care needs in the state, determine the populations most at-risk of HIV infection, and recommend effective prevention strategies to reach these populations.

The ICPC's decisions are based on many sources of data, including an epidemiological profile of who is infected in Idaho, population-specific needs assessments, and studies of what interventions have proven to be successful in reducing HIV.

The ICPC incorporates the views, knowledge and experiences of many individuals and agencies. ICPC membership includes persons infected by HIV, persons representing populations at risk of HIV, HIV prevention and care providers, health department representatives, educators, and persons with expertise in behavioral science, substance abuse, corrections, health planning, epidemiology, and evaluation. The ICPC leadership ensures that that every member is included equally in meeting discussions and decision-making.

Structure

With an allowable membership of up to 40 persons, the ICPC currently stands at 24 members. Terms of membership are three years, with the option to reapply. The Community Co-Chair and Health Co-Chair are both elected by the membership. The Council meets three times per year for 2-3 day sessions. In addition, ICPC committees meet by conference call and in-person at least six times per year. The ICPC has five working committees:

Needs Assessment Committee assesses the prevention and care needs of Idaho's at-risk populations using epidemiological and other data, both primary and secondary, to determine what the precise needs of at-risk populations are in regards to both prevention and care.

Gap Analysis Committee analyzes the data produced by the needs assessments, Resource Inventory, epi profile, and other data to determine the gaps and barriers to successful prevention and care in the state of Idaho.

Prevention Intervention Committee takes data from the needs assessments, resource inventory, and gap analysis to research and recommend prevention interventions that are evidence-based, feasible, and appropriate for specific populations.

Care Services Committee recommends solutions to address gaps and barriers to care identified by the gap analysis, develops long and short-term care services goals, describes the existing continuum of care, and assists in developing the state's services delivery plan.

Administrative Committee develops member recruitment goals and plans, accepts and reviews both new member and renewal applications, recommends ICPC membership for approval by the Executive Committee, follows up with absentee members, and ensures that there are appropriate guides and tools for new members.

An ICPC Executive Committee is comprised of the chairs from each of the above committees, as well as the ICPC Co-Chairs and STD/AIDS Program Manager. The Executive Committee approves membership applications, guides the community planning process, and handles other issues such as conflict of interest. The Executive Committee meets monthly by conference call to coordinate community planning tasks and deal with administrative issues.

Member Support

The Idaho STD/AIDS Program provides all ICPC members with an ICPC Orientation Guide and an ICPC Membership Manual. The Orientation Guide describes:

- ✓ Mission and purpose of the ICPC.
- ✓ Goals, objectives, principles and steps of community planning.
- ✓ Importance of parity, inclusion and representation.
- ✓ Functioning of the ICPC, including structure, ground rules, meetings, conflict of interest.

The Manual provides:

- ✓ More in-depth information on community planning.
- ✓ ICPC bylaws (please see Appendix A).
- ✓ CDC Community Planning Guidance.
- ✓ Current Idaho HIV/AIDS Epidemiologic Profile and STD statistics.
- ✓ Current HIV Prevention Comprehensive Plan.
- ✓ ICPC Membership Directory.
- ✓ ICPC committee roles.

The Idaho STD/AIDS Program and ICPC leadership support the ongoing training, knowledge development, and participation of all ICPC members.

- ✓ All new members receive a two hour orientation (please see Appendix A).
- ✓ The Executive Committee provides mentoring to new members during and after their first meeting.
- ✓ All members serve on an ICPC working committee.

- ✓ The Co-Chairs and several additional ICPC members attend the HIV Prevention Leadership Summit annually.
- ✓ National and regional technical assistance experts meet with the ICPC on specific community planning issues at least annually.
- ✓ National studies, guidances and other materials related to community planning, HIV prevention, and HIV/AIDS care are disseminated to members on a regular basis.
- ✓ Leadership training is provided to all committee chairs.
- ✓ An STD/AIDS Program liaison is assigned to each ICPC committee to arrange for any specific technical assistance or support needs of these groups.
- ✓ Reports on the prevention and care services funded in Idaho are provided to the ICPC at least annually.
- ✓ A review of how Idaho STD/AIDS prevention funds are allocated, by population and intervention type, is presented to the ICPC annually.
- ✓ An annual Idaho STD/AIDS Conference is co-sponsored by the Idaho STD/AIDS Program and the Idaho Department of Education.

Member Involvement

ICPC members are actively involved in all aspects of community planning. Members develop the Council's bylaws, recruit and approve new members, participate in the development of meeting agendas, chair the meetings, and lead working committees.

Together, ICPC members examine planning data, prioritize Idaho's populations most at risk of HIV infection, and select the most effective interventions to reach these groups. After these decisions are made, ICPC members review the state's comprehensive HIV prevention plan and funding application to ensure their priorities are incorporated. The ICPC then evaluates its planning process and sets goals for continuous improvement.

Idaho's Community Planning Timeline

Idaho has a three-year community planning cycle. This 2005 Update of the 2004-2006 Comprehensive Plan outlines community planning activities for 2005:

January	Complete needs assessment report for High Risk Heterosexual (HRH) target population, including youth ages 13-24 and HIV+ HRH.
January - March	Update HIV Prevention and Care Resource Inventory.
March - April	Using the Resource Inventory, epi data, and the HRH needs assessment results, conduct a gap analysis of HIV prevention services for HRH.
January – May	Research HRH evidence-based prevention interventions for the ICPC to consider.
February ICPC Meeting	• Conduct new member orientation • Review how the Idaho STD/AIDS Program has allocated funds for 2005 prevention services. • Review HRH Needs Assessment report. • Review current epidemiological profile. • Receive reports on challenges and successes of Idaho's current HIV prevention interventions. • Complete conflict of interest self-disclosure forms. • Hold meetings of the five ICPC working committees.
May or June ICPC Meeting	• Review Resource Inventory (mailed in advance). • Review HRH Gap Analysis report (mailed in advance). • Update priority populations as needed. • Select interventions for HRH population, using recommendations presented by the Prevention Intervention Committee. • Update prevention interventions for Idaho's other priority populations as needed. • Hold meetings of the five ICPC working committees. • Evaluate the community planning process.
May – August	Identify membership gaps and recruit new members as needed, led by the Administrative Committee.
August – September	Review Idaho's Comprehensive Plan update and funding application and prepare letters of concurrence or non-concurrence.
October or November ICPC Meeting	• Obtain technical assistance from national network as needed. • Arrange other ICPC capacity building sessions as needed. • Receive reports on challenges and successes of Idaho's currently funded HIV prevention interventions. • Hold meetings of the five ICPC working committees.

Idaho's Comprehensive HIV Prevention Program

The Centers for Disease Control and Prevention (CDC) defines a comprehensive prevention program as having nine essential components. A summary overview of Idaho's HIV prevention program is provided below. The Idaho STD/AIDS Program's funding application to the CDC offers further details on each component.

1. HIV Prevention Community Planning

The Idaho STD/AIDS Program has formed a statewide community planning group to develop Idaho's comprehensive plan for HIV prevention. The Idaho HIV Care and Prevention Council provides for broad-based community participation in identifying the state's priority prevention needs and ensuring that Idaho's prevention resources target these needs.

2. HIV Prevention Activities

a) Counseling, testing, and referral services. HIV testing is offered at Idaho's seven district health departments and their 32 satellite clinics, as well as non-clinic settings to reach at risk populations. Efforts are being made to reach those unaware they may be HIV+ and to reach those who may be infected earlier in their disease stage. Testing providers strive to ensure that all those who are tested receive their results, and that there is comprehensive follow-up to those who test positive to connect them to care services. Providers follow CDC's *Revised Guidelines for HIV Counseling, Testing, and Referral*. A pilot of the HIV rapid test was conducted in 2004.

b) Partner counseling and referral services. These services are provided by health district personnel in collaboration with other medical providers statewide. Staff receive training based on CDC's guidelines for effective service delivery.

c) Prevention for HIV-infected persons. In 2004, HIV+ persons in Ryan White case management programs were assessed for their need for more intensive Prevention Case Management services. This behavioral intervention helps HIV+ persons initiate and sustain practices that limit the transmission of HIV.

d) Health education and risk reduction activities. These organized HIV prevention activities reach Idaho's populations most at risk of becoming HIV infected, as well as persons who are already infected. Activities for 2005 are based on the recommendations of the Idaho HIV Care and Prevention Council. They include individual level interventions, group level interventions, outreach and educational efforts. Interventions selected are based on proven effectiveness, behavioral theory, and appropriateness to Idaho's priority populations. Specific interventions are described further in this plan.

e) Public information programs. The Idaho STD/AIDS Program is entering its third year of a five year statewide media campaign. The goal is to shift prevention

responsibility from external (someone else) to personal responsibility and getting at-risk persons tested. At the local level, prevention contractors around the state conduct public information activities around World AIDS Day and National Testing Day, as well as Pride events.

f) Perinatal transmission prevention. The Idaho STD/AIDS Program does not meet eligibility criteria for the funding of this service. However, the Program will continue to promote routine, universal HIV screening for pregnant patients.

3. Quality Assurance

In 2004, the Idaho STD/AIDS Program developed a comprehensive site visit tool for monitoring public and private sector HIV prevention contractors. This on-site tool assesses quality assurance policies and procedures in regard to delivering HIV counseling and testing services, prevention for positives, evaluating prevention interventions, financial management and contract compliance.

4. Evaluation and Data Collection

Process monitoring. Prevention contractors submit intervention reporting forms to the STD/AIDS Program on a monthly basis. These forms reflect the CDC Evaluation Guidance and include numbers and risk category(ies) of persons who were actually reached, quantitative data on the specific interventions, and resources used to conduct the intervention(s).

Contractor reports are entered into a data base developed specifically for the purpose of producing aggregate data. The reports generated follow the format and requirements outlined in the CDC's Evaluation Guidance for reporting to CDC. Technical assistance on reporting and evaluation is provided to contract organizations on an ongoing basis through site visits, email and telephone.

The CDC's Performance Evaluation Monitoring System (PEMS) will be implemented in 2005, first through adapted hard-copy reporting forms, and eventually through online reporting.

Outcome monitoring. A statewide HIV prevention outcome monitoring evaluation has been developed and piloted for validity and reliability. Outcome information collected by contractors is entered into a data base, and the outcome summaries are then discussed with individual contractors to evaluate the efficacy of their interventions.

In addition, contractors that offer group level, individual level and prevention case management interventions are required to initiate an outcome evaluation of their services. Technical assistance is provided to the contracting organizations for development of their survey instruments to specifically address measurement of the individual goals of their program(s), while ensuring alignment with the indicator requirements of CDC initiatives.

Again, outcome collection will be adapted to the new PEMS.

5. Capacity-Building Activities

The STD/AIDS Program will integrate a capacity building assessment into the contractor annual site visit. Information gathered in 2004-2005 will help formulate a plan for 2006-2008. The capacity-building plan will include training for HIV counseling and testing, partner counseling and referral, and implementation and evaluation of prevention interventions. Capacity building will also address a contractor organization's ability to manage prevention intervention programs.

6. STD Prevention Activities

The STD/AIDS Program contracts with the seven health districts for diagnostic, treatment and epidemiological services for clients suspected of having a sexually transmitted disease. As a result of a department-wide "Any Door Initiative," the HIV and STD surveillance and epidemiological services has been moved into the Office of Epidemiology. Because both programs are housed in the same building and on the same floor it is anticipated the service provided and collaboration between the two programs will not change.

7. Collaboration and Coordination wit Other Related Programs

Substance Abuse: At the district level, prevention contractors work closely with treatment facilities in implementing prevention interventions. At the state level, the STD/AIDS Program sponsors on-site testing in state-funded substance abuse treatment facilities. In 2003, the state substance abuse program collaborated in assessing the HIV prevention needs of injection drug users.

Corrections: The STD/AIDS Program continues to co-fund testing of inmates through the State Laboratory and provide follow-up on positive tests. Three group level interventions are funded to provide HIV prevention in correctional facilities. Two of these interventions are at the Idaho State Women's Prison in Boise and Pocatello and one in northern Idaho at the Men's Correctional Facility in Orofino.

Education: The Idaho STD/AIDS Program works closely with the Idaho Department of Education in several ways: a joint HIV materials review panel, health communication/public information projects, and a jointly sponsored annual state STD/AIDS Conference. The STD/AIDS Program supports outreach to alternative schools, and provides school personnel with training and technical assistance on STD/AIDS. At the local level, the health districts provide HIV/STD education to local school districts.

Sexually Transmitted Diseases: In Idaho, clients that have been diagnosed with an STD are considered high risk for HIV. The STD/AIDS Program funds the health districts to provide HIV testing to the clients with an STD diagnosis. Annually the STD/AIDS program produces an STD fact book that includes STD and HIV rates.

Tuberculosis: In Idaho, all tuberculosis cases annually are cross referenced with HIV case reports. There has not been a positive TB case that has been co-infected with HIV in many

years. It is the state's recommendation that those who test positive for tuberculosis between the ages of 18-34 are also counseled and tested for HIV.

HIV Care and Treatment: In 2003, the Idaho Prevention Planning Group (IPPG) became the Idaho HIV Care and Prevention Council (ICPC), which works collaboratively to conduct both care and prevention planning activities. In a rural state where many of the care providers are also prevention providers this seemed to be a very efficient way to complete both planning efforts. The State HIV Prevention Coordinator and State Ryan White Title II Coordinator collaborated on a Prevention for Positives program that was implemented in 2004.

Family Planning: In 2004, the Idaho STD/AIDS Program and the Family Planning Program conducted joint site visits to health district contractors. Both programs offer HIV testing. The goal is to verify coordination without duplication of services with our local providers.

Hepatitis: The state Hepatitis B Coordinator is within the Immunization Program, the Hepatitis C Coordinator is within the Office of Epidemiology, and the HIV Prevention Coordinator is within the STD/AIDS Program. The three coordinators have met to identify ways of coordinating services and public education. The Hepatitis C coordinators at the districts have developed a hepatitis C assessment tool that is administered to all clients in HIV, STD, and family planning clinics. Plans for future coordination may include providing the Hepatitis B vaccine to those individuals that are HIV positive and test negative for Hepatitis B.

Tribal communities: In 2003, the STD/AIDS Program awarded the Nez Perce Tribe a three-year contract for HIV prevention activities on the Nez Perce reservation. The funded intervention is a peer-based program for Native American youth. Two of Idaho's six tribes were also represented on the Idaho HIV Care and Prevention Council.

8. Laboratory Support

The STD/AIDS Program supports the cost of HIV testing for specimens obtained through its counseling and testing program. Approximately 1,900 specimens annually have been processed from clients in the high/highest risk behavior categories during the past three years. The STD/AIDS Program provides financial assistance to the Bureau of Laboratories (BOL) for the cost of laboratory services.

9. HIV/AIDS Epidemiologic and Behavioral Surveillance

The Idaho STD/AIDS Program will not be requesting funding for surveillance activities in its HIV prevention application. HIV Surveillance activities will be conducted through the Office of Epidemiology and Disease Prevention. STD/AIDS staff will continue to collaborate with this program for surveillance activities.

Idaho's HIV Prevention Plan for 2004-2006
2005 Update

Introduction

This section of the Comprehensive Plan presents the data the Idaho HIV Care and Prevention Council (ICPC) used in its community planning decisions. These tools include:

- ✓ The Epidemiologic Profile of HIV/AIDS in Idaho
- ✓ Summary needs assessment findings for Idaho's priority populations: HIV+ persons, men who have sex with men (MSM), women at-risk (now high-risk heterosexuals), and injection drug users (IDU).
- ✓ A Resource Inventory of Idaho's HIV Prevention and Care Services.
- ✓ A Gap Analysis of Idaho's HIV prevention needs.

The HIV prevention priorities and recommendations set by the ICPC are then described. These include:

- ✓ Idaho's priority populations for HIV prevention services.
- ✓ Evidence-based prevention interventions to reach these populations.

Epidemiologic Profile

Idaho's Epidemiologic Profile of HIV/AIDS is included as Appendix D.

Needs Assessments of Idaho's Priority Populations

Men Who Have Sex With Men

Introduction
In 2004, Clearwater Research, working closely with representatives of the Idaho Department of Health and Welfare STD/AIDS Program and the HIV Prevention and Care Council Needs Assessment Committee, designed and implemented a web survey, as well as an identical mail survey, targeted toward gay men throughout the state of Idaho. Survey data was collected from February to April, 2004. A total of 178 completed interviews were received between the mail and web surveys.

Sexual Orientation "Openness"
Respondents were most open about their sexual orientation status to their mothers, siblings, straight friends, and medical providers. Groups or individuals who gay men appeared to talk less candidly with about their sexual orientation status included strangers/new acquaintances, and members and leaders of their religious community.

Internalized Homophobia
Although the majority of respondents provided answers to four internalized homophobia questions that would indicate they are not conflicted about their sexual orientation status (i.e., not harboring feelings of internalized homophobia) and in fact are glad to be gay, a small minority of respondents did appear to have some level of internalized homophobia. For instance, 19% of respondents indicated some level of agreement with the statement "I wish I were heterosexual".

Ongoing Sexual Relationships
Sixty-eight percent of respondents had been in an ongoing sexual relationship with a man over the past twelve months. Results of questions about condom use within the ongoing sexual relationship were mixed. A relatively high percentage of respondents, 42% and 46%, respectively, said they never or seldom use condoms when receiving or giving anal sex. However, many other respondents, 51% and 46%, respectively, indicated they frequently (more than 50% or always) use condoms when having anal sex. Very few respondents in ongoing sexual relationships said they used condoms when giving or receiving anal sex.

Casual Sexual Relationships
Sixty-eight percent of respondents also reported being involved in a casual sexual relationship with a man over the past twelve months. When compared to their peers in ongoing sexual relationships, respondents who reported having had casual sex were substantially more likely to report they always use a condom when giving or receiving anal sex. However, like those

involved in ongoing sexual relationships, the majority of respondents who engaged in casual sexual relationships reported that they never use condoms when giving or receiving oral sex.

A small percentage of respondents who reported having casual sexual relationships in the past year appeared to be unempowered in terms of their ability to talk to sexual partners about HIV and safe sex. Fourteen percent of respondents said they never talk to partners about HIV and 15% said they never talk to partners about safe sex. Further, 44% indicated that they did not know the HIV status of at least one of the casual partners they have had in the past year.

General Sexual Behavior

The majority of respondents (82%) indicated they only had sex with men over the course of the past year. Forty percent of respondents had six or more partners over the past year, and 91% had two or more partners over the past year. A substantial proportion of respondents reported meeting their sexual partners through the Internet, through friends, at bars/dance clubs, or at gay events.

Over one quarter of respondents (26%) said that during the past year they had engaged in unplanned or casual sex while under the influence of drugs or alcohol. Situations and times that appeared to engender gay men having unprotected sex at potentially high rates were sex with a woman, sex with a stranger, and feelings of depression.

HIV (Attitudes and Testing) and STDs

Twenty percent of respondents reported that they had never been tested for HIV. The main reasons respondents had not been tested included feeling at low risk for HIV and not having been sexually active. Among those respondents who had been tested, 84% said the result of their last HIV test was “HIV negative”.

Only 9% of respondents indicated they believed they had some likelihood of becoming infected with HIV or getting AIDS. However, 22% of respondents indicated they either did not know if they had put themselves or a partner at risk for HIV or said that they had indeed put themselves or a partner at risk for HIV over the last year.

Service Provision and Need

Areas of substantial unmet service need included dental care, medical care, financial assistance, relations with friends, and relations with family. Areas of comparatively little need were drug/alcohol treatment services, safer injection techniques, and domestic violence assistance.

Women at Risk

In 2000-2001, the ICPC assessed the HIV prevention needs of women perceived to be at risk for infection through partners who were MSM, IDU or HIV+, or through other risk behaviors. Settings for survey collection included prisons, jails, STD clinics, substance abuse treatment facilities, and alternative schools. A total of 510 women were surveyed. Of those surveyed:

- ✓ Just under one-quarter (23%) reported a known direct risk behavior over the past year (sharing needles, trading sex for money or drugs, having unprotected sex with a known high-risk partner).

- ✓ Another 35% of the women reported more indirect risk behaviors, such as injecting drugs, having sex with someone who has multiple sex partners, having sex with a casual acquaintance, or using drugs immediately prior to sex.

- ✓ The remaining 42% of the women were aware of no apparent risk. These women tended to be older, more educated, and more rural than the first two groups.

- ✓ Among the women reporting higher rates of risk behavior, only 11% claimed they always used condoms. The top reasons for not using condoms were: 1) sex with a regular partner, 2) partner resistance, 3) sex less exciting with a condom, and 4) drug use.

- ✓ All the women surveyed reported common concerns and barriers to HIV testing: fear, waiting, cost, and anonymity.

Injection Drug Users

In Spring, 2003, a statewide needs assessment was conducted of the HIV prevention needs of persons who inject drugs. An 85-item survey developed by the ICPC was offered to IDUs via HIV prevention and care providers, substance abuse treatment centers, correctional facilities, and networks known to IDU representatives on the ICPC. 126 surveys are included in this analysis.

Demographics. Of those surveyed, 71% were female and 29% male. Almost half (49%) were ages 19-25 and 40% were ages 26-35. The remaining respondents were under age 19 (1%) or over age 35 (10%). The respondents' race/ethnicity was 84% white, 6% Hispanic, 6% Native American, and 4% Black. The participants' sexual identify broke out as 54% heterosexual, 27% bisexual, 7% gay and 12% no response.

HIV Status. One person disclosed they were HIV positive and 21% reported they were unsure of their status. 18% of the IDUs sampled were unsure of their partner's HIV status.

Partner as IDUs. Over half of the IDUs participating in the study reported their partners used injection drugs. Females reported a higher rate (53% of partners) when compared to males (38% of partners).

Injection Risk Behaviors. IDUs were asked about the risky injection-related behaviors they engaged in over the last 30 days. Half reported using a needle that was used by someone else. Nearly half reported using a needle when they did not know if it was clean or dirty. 60% reported sharing cotton, cookers, and water. 56% gave their used needles to others. Only 10% reported always using bleach and water to clean their works. When asked if they discussed HIV/AIDS with those that they inject drugs with, 81% reported no.

Obtaining Needles**.** The pharmacy was the preferred location to obtain syringes (43%). This was followed by friends (25%), drug dealers (13%), significant others (9%), diabetics (6%), shooting gallery (2%) and other (2%).

Sexual Risk Behaviors. Seventy-one percent of surveyed IDUs reported having sex in the last 6 months. Of those, 79% had vaginal sex without a condom, 73% had oral sex without a condom, and 28% anal sex without a condom. Eleven percent reported exchanging sex for money/drugs and 14% engaged in anonymous sex in the last 6 months. Over half (59%) were comfortable discussing HIV with their sex partners and 67% were at ease discussing condoms.

Other needs. IDUs were asked if any of 10 different life domains were a source of difficulty. The areas with the most difficulty were drug use (65%) and money issues (65%). These were followed by family troubles (62%) and legal matters (60%). Areas causing the least, but still significant difficulty, were housing (43%) and transportation (42%). Respondents were also asked about help needed with any of 13 different life domains. The areas needing the most help were drug and alcohol use (68%), and dental care (62%). Help with medical care (59%) ranked third.

Inventory of Idaho's HIV Prevention Resources

The Idaho STD/AIDS Program updated the Resource Inventory in early 2004. The document lists services by health district. A map of Idaho's seven health districts can be found in Appendix C.

Idaho HIV Care and Prevention Resource Inventory: 2004

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
Statewide	Please see District level information	AIDS Drug Assistance Program Idaho STD/AIDS Program 334-5943	Housing Opportunities for Persons With AIDS (HOPWA) 877-438-4472				Idaho Legal AID 1-877-500-2980	Alcoholics Anonymous (AA)
	Idaho Department of Health and Welfare STD/AIDS Program 450 W. State Street PO Box 83720 Boise ID 83720-0036 208-334-6527 fax 208-332-7346	AIDS Clinical Trials Information *800-874-2572*	Idaho Domestic Violence Programs 24 hour hotline 1-800-291-0463				Social Security Administration 1-800-772-1213	Suicide Prevention Hotline 1-800-949-0057
	Project Inform www.projinf.org	Center for Positive Connections 888-POS-CONN (767-2666)					Idaho Department of Health and Welfare 211 or 334-5945 for the Division of Health	Narcotics Anonymous (NA)
	Teen AIDS-Peer Corps www.teenaids.org	National Native American AIDS Prevention Center www.nnaapc.org					Idaho State Bar Association Lawyer Referral Service 1-208-334-4500	Idaho Department of Health and Welfare Mental Health Services Regional Health 1-800-600-0800 Mobile Crisis Center 1-800-600-6474
		HIV Positive Heterosexual Support Site www.positiveconnections.org					Idaho Human Rights Commission 208-334-2873	
		Gay Men's Health Crisis New York NY 212-807-6655					Co-Ad Inc. State Advocacy Program for Idahoans with disabilities. 1-800-632-5125	

		Centers for Disease Control & Prevention (CDC) www.cdc.gov/hiv					Idaho Department of Labor Job Service Boise 334-6700	

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 1	North Idaho AIDS Coalition Coeur d'Alene, ID GLIs with MSM GLI for Women at-Risk ILI for HIV- MSM HIV+ Support Group 208-665-1448	North Idaho AIDS Coalition 410 Sherman Ave Suite 215 Coeur d'Alene, ID 83814 HIV+ Case Management 208-665-1448	Idaho Housing & Finance Assoc. 610 W Hubbard Suite 219 Coeur d'Alene, ID 83814 208-667-3380	Community Action Agency 4942 Industrial Ave East Coeur d'Alene, ID 83815 208-664-8757	NICE/CATS Bus Coeur d'Alene, ID *Accepts Medicaid 208-664-9769	Community Health Assoc of Spokane 9227 E Main Spokane, WA 99206 Medical/Dental 509-444-8200	Social Security Administration Coeur d'Alene Office 765-1322 TTY 667-0940	Community Health Assoc. of Spokane 9227 E Main Spokane WA 99206 Mental Health 509-444-8200
	Panhandle District Health Department HIV Testing 2195 Ironwood Ct. Coeur d'Alene ID 83814 667-3481	Community Health Association of Spokane (CHAS) Spokane, WA HIV+ Case Management Ryan White Clinic 509-444-8200	St. Vincent DePaul Social Services 108 E Walnut Coeur d'Alene, ID 83814 Emergency shelter/transitional housing 208-664-3095		CHAS 2227 E Main Spokane, WA 99206 *Transportation to/from RW3 medical/dental health appts. 509-444-8200	Dr.Zugec Lance Varns, ARNP CHAS Spokane, WA 99206 509-444-8200	Idaho Legal Aid 1-877-500-2980 667-9559	NorthWest Behavioral Health 1620 NorthWest Blvd Ste, C-201 Coeur d'Alene, ID 83814 In/Outpatient mental health, substance abuse treatment – Medicaid 208-765-4509
		Idaho Care Line 800-926-2588				Dr. Coulston Deaconess Doctor's Building 801 W. 5th Ave. Swt.504B Spokane, WA 99204 509-623-1456	Veterans Services 208-769-4400	HighRoad Human Services PO Box 1550 Coeur d'Alene, ID 83816 Mental health case management 208-667-3118
		District 1 Health Dept. Program Contact: Lora Whalen 666-0603 lwhalen @phd1				Dr. Collins Phys Clinic Spokane, WA 99204 800-325-7940 509-747-1144		Port of Hope 218 N. 23rd Coeur d'Alene, ID 83614-5411 Substance Abuse Treatment 208-664-3300
						Dr. Puffer 502 N 2nd.Ave Sandpoint, ID 83864 208-263-3111		Behavioral Health 2301 N Ironwood Place Coeur D'Alene ID 83814 (Inpt. Mental Health-Medicaid, Substance Abuse) 208-765-4800

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
						Dr. Daughtery-Fowler 2207 Ironwood PL. Coeur d'Alene ID 83814		CHAS RW III 9227 E. Main Spokane WA 99206 (Mental Health) 509-444-8200
						Dr Osborn VAMC 4815 N. Assembly Spokane, WA 99205-6197 800-325-7940		

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 2	North Central District Health Dept. Lewiston, ID 83501 GLI with IDU Inmates GLI with HIV+ MSM HIV testing at 5 sites 208-799-3100	North Central District Health Dept. 215 10th Street Lewiston ID 83501 Jenny Beegle, Prevention Advocate 208-799-3100	HOPWA North Central District Health Dept. 215 10th Street Lewiston, ID 83501 Jenny Beegle, Case Manager 208-799-3100	Community Action Partnership Food Bank 1240 New 6th St. Lewiston, ID 83501 Food boxes, perishable foods, Clearinghouse 208-746-3351	Valley Transit Regional Public Transportation 1424 Main Street Lewiston, ID 83501-1907 743-2545	Dr. Michael Rooney Internal Medicine/ Oncology 428 6th Ave Lewiston ID 83501 743-7427	Consumer Credit Counseling Linda Rockefeller (208) 746-0127	Phillips Agency 532 Bryden Avenue Lewiston, ID 83501 208 798-5168.
	Confidential Testing HIV Lewiston 799-3100 Moscow 882-7506 Orofino 476-7850 Grangeville 983-2842 Kamiah 935-2124	North Central Health Dept: Program Contact Dianne Waldemarson dwaldem@phd2.state.id.us 799-3100	Sojourners' Alliance 627 Van Buren St. Moscow, ID 83843 (208) 883-3438 Homeless shelter and emergency housing.	Soup Kitchen Salvation Army 1835 G Street Lewiston, ID 83501 208-746-9653	All Ways Transportation Lewiston, ID 931 B Bryden 83501 746-0257 Medicaid Transportation provider	Dr. Coulston Deaconess Doctor's Building 801 W. 5th Ave. Swt.504B Spokane, WA 99204 509-623-1456	SSI Disability Determination Boise ID 1-800-626-2681	Riverside Recovery 1770 18th Ave Lewiston ID 83501 746-4097
	Sojourners' Alliance Stonewall Health Project GLI for MSM 208 883-3438	CHAS 9227 E. Main Spokane, WA 99206 509-444-8200	YWCA Homeless Center 300 Main St. Lewiston, ID 83501 746-9655	Nez Perce County Food Bank 208-743-4362	Interlink Volunteers 817 6th Street Clarkston, WA 509 751-9143	Nimiipuu Health Clinic 210 Beaver Grade Lapwai, ID 843-2271	SSA Office Lewiston ID TTY 208-746-9972 746-2995	AA Lewiston-Clarkston 509 758-2821 Moscow ID 208 882-1597
	Nez Perce Tribe Students for Success GLI, ILI, & HC/PI with youth. Joyce Mc Farland Program Director 208-843-2253		IHFA Kathy Kernan 215 10th Street Lewiston, ID 83501 208-743-0251	NEZ Perce Tribe Commodity Foods And Warehouse 843-2391	CHAS 9227 E Main Spokane, WA 99206 *Transportation to/from RW3 medical/dental health appts. 509-444-8200	St. Joseph's Regional Medical Center 415 6th Street Lewiston, ID 83501 208- 743-2511	Idaho Legal Aid 1-877-500-2980	Crisis Services/Suicide 1-800-669-3176 746/9655

			Idaho Veterans Home 821 21st Avenue Lewiston, ID 83501 208-799-0251		Medicaid Transportation Unit Lewiston, ID *1-800-296-0509*	Gritman Medical Center 700 South Main Moscow, ID 208-882-4511		CHAS 9227 E Main Spokane, WA 99206 509-444-8200
						Dr. Chad Barmey DMD 328 St. John's Way Lewiston, ID 83501 208-746-1771		Sequoia Counseling Fran Caradine MSW 802 Bryden Avenue Lewiston, ID 83501 208-798-1646
						Moscow Family Medicine Dr. Dan Schmidt 623 S. Main Moscow, ID 83843 208-882-2011		NEZ Perce Tribe Drug and Alcohol Abuse Program 843-2391
						Dr. Bradley Morlock Periodontist 3323 4th Street Lewiston, ID 83501 208-743-1114		

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 3	Southwest District Health Department 920 Main Street Caldwell ID 83605 GLIs with IDUs Outreach ,HC/PI HIV Testing 208-455-5300	HIV Services Clinic 777 N Raymond St Boise, ID 83704 208-367-7033	Idaho Migrant Council Caldwell, ID	Idaho Food Bank Boise ID 336-9643	Idaho Migrant Council Caldwell, ID 454-1652	Terry Reilly Health Services. C/MHS Primary Care, Dental Nampa 466-7869 Caldwell Homedale Marsing	Idaho STD/AIDS Program 450 W. State 4th FL. Boise ID 83720 AIDS Drug Assistance Program – 334-5943 Direct Care Services 334-6657	Terry Reilly Health Services Nampa ID 467-7654
		Southwest Dist. Health Dept. Program Contact: Jan Edmonds jedmonds@phd3 455-5392	Hope House Nampa ID 463-0118	Western Idaho Community Action Payette, ID 642-4436		Mercy Medical Center Nampa ID 463-5000 TTY 463-5427	Idaho Legal Aid Low income Legal Assistance 454-2591	Port of Hope Nampa ID 463-0118
						West Valley Medical Center Caldwell ID 459-4641	Idaho Migrant Council Emergency Assistance & Referral Service 454-8604	Suicide Hotline Crisis Intervention Open 24 Hours a Day Nampa 888-5000 Emmett 365-3080
							Social Security 800-772-1213 454-3096 TTY 208-455-1002	

District 4

HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
Mountain States Group 1607 W. Jefferson St. Boise, ID 83706 Women's Prison Project GLI with IDU female inmates BOI O BOI Project Duane Quintana GLI, ILI, Outreach and HC/PI with MSM 208-336-5533	Central District Health Department Safety Net of AIDS Program 707 N Armstrong Pl. Boise ID 375-5211	Boise City/Ada County Housing Authority 1276 River Street Ste. 300 Boise ID 83702 345-4907	Idaho Food Bank Boise ID 336-9643	Boise Urban Stages Boise ID 336-1010	Terry Reilly Health Services C/MHS Primary Care, Dental Boise	Idaho STD/AIDS Program 450 W. State 4th FL. Boise ID 83720 AIDS Drug Assistance Program – 334-5943 Direct Care Services 334-6657	Saint Alphonsus Behavioral Health Center Addiction Recovery Center Boise, Nampa ID 367-3553
El Ada Community Action GLI with Women at-Risk ILI with Persons at-Risk Outreach 3553 Americana Terrace Boise ID 83706 208-345-2820	Family Practice Ryan White Clinic Care Case Management Testing Support Groups Boise ID 208-367-7033	Community House Boise ID 389-9840	El Ada Community Action Boise ID 377-0700 377-0760		Central District Health Dept. 707 N Armstrong Pl Boise ID 83704 Boise & Boise County 327-7400 Mountain Home 587-4407 McCall 634-7194 Horseshoe Bend	St. Vincent DePaul FreeMed Program 215 W. 35th Street Garden City ID 83714 384-5200	Intermountain Hospital Boise, ID 377-5548
Planned Parenthood GLI, Outreach and HC/PI for Youth and Women at-Risk HIV Testing 6111 Clinton Boise ID 83704 376-9300	Boise City/Ada County Housing Authority 1276 River Street Ste. 300 Boise ID 83702 345-4907	City Light Boise ID Women with substance abuse issues 368-9901			Genesis Free Clinic 215 West 35th St. Garden City ID 83714 384-5200	Social Security 800-772-1213 321-2900 TTY 208-321-2902	SunHealth Behavioral Health Boise ID 327-0504
	Central District Health Dept. Program Contact: Linda Knopp lknopp@phd4 327-8518 HIV-STD Testing	Boise Rescue Mission Boise ID 343-2491			St. Vincent DePaul FreeMed Program 215 W. 35th Street Garden City ID 83714 384-5200		Suicide Hotline Crisis Intervention Boise 376-5000 Mountain Home 587-3300

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 4						Saint Alphonsus Regional Medical Center Boise ID 367-2121		
						Family Practice Ryan White Clinic 376-6079		
						Planned Parenthood Boise ID 376-9300 Twin Falls 734-9955		

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 5	South Central District Health Dept. GLI for Youth HC/PI for IDU HIV Testing 734-5900,ext. 269	South Central District Health Department Case Management for HIV+ Persons Tom Machala tmachala@phd5 734-5900 (263) Mary Sass 734-5900 (269)	Valley House Homeless Shelter Twin Falls, ID 734-7736	South Central Community Action (food boxes & commodities) Jerome, 342-8856 Burley, 678-3514 Twin Falls, 734-2307 550 Washington St South	Trans IV Twin Falls, ID 736-2133	South Central District Health Dept. Jerome 324-8834 Hailey 788-7335 Burley 678-8221 Rupert 436-7185 Gooding 934-4477 Twin Falls 734-5900	Consumer Credit Management Services 800 Falls Ave. 733-2227	Canyon View Psychiatric & Addiction Services Twin Falls, ID 734-6760
	South Central Idaho AIDS Coalition 734-5900 ext 269	Hospice Visions 308 Shoshone St. E Suite 1 Twin Falls ID 735-0121	Twin Falls Housing Authority Twin Falls, ID 733-5765	Salvation Army HOT MEALS Twin Falls, ID 348 4th Ave N. 733-8720	Interfaith Volunteer Caregivers Twin Falls, ID 733-6333	Cassia Regional Medical Center 1501 Hiland Ave Burley, ID 678-4444	Social Security Administration 1437 Fillmore St. 800-772-1213 734-3985 TTY 735-8203	Dr. Robison 493 Eastland Dr. Twin Falls, ID 83301 732-0995 Mental Health
		Hospice of Wood River Valley 507 1st Ave N Hailey, ID 726-8464	Idaho Housing & Finance Association 844 Washington North 734-8531	St. Edward's HOT MEALS 152 7th Ave E Twin Falls, ID 734-2466	Idaho Migrant Council Twin Falls, Burley	Minidoka Memorial Hospital 1224 8th Ave Rupert, ID 436-0481	Idaho Migrant Council 734-3336	PFLAG (Parents and Friends of Lesbians & Gays) Twin Falls, ID 733-9172
		Family Practice Ryan White Clinic Boise, ID 367-6030	Housing Opportunities for People with AIDS 877-438-4472	St. Jerome's HOT MEALS 216 2nd Ave E Jerome, ID 324-8794		St. Luke's Wood River Med Ctr 100 Hospital Dr. Ketchum, ID 727-8800	Veterans Admin. 1-800-827-1000	Walker Center (alcoholism & chemical dependence treatment) 149 Main Ave.East Twin Falls 734-4200 605 11th Ave East Gooding 934-8461
		South Central Community Action Medication assistance Jerome 324-8856 Burley 678-3514 Twin Falls 734-2307		Idaho Migrant Council 406 Gardner Ave Twin Falls 734-9172 3937 Overland Ave Burley 678-1171		St. Benedict's Family Med Center 709 N Lincoln Jerome, ID 324-4301	South Central Community Action (gas, medication, and energy assistance) Jerome 324-8856 Burley 678-3514 Twin Falls 733-9351	Fellowship Hall Twin Falls, ID 736-0918

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 5		South Central Idaho AIDS Coalition 213 E. Ave D Jerome ID 324-8480				Magic Valley Regional Medical Center 650 Addison Ave. W Twin Falls, ID 737-2000	Idaho Legal Aid Services 734-7024	HIV/AIDS Support Group 733-3129 (ask for Jane)
		HIV/AIDS Support Group Twin Falls, ID 733-3129 (ask for Jane)				Family Health Services 388 Martin Twin Falls, ID 734-0451		Mental Health Services – Health & Welfare, Region V Burley 435-9494 Wood River Valley 788-3584 Jerome 324-8862 Twin Falls 736-2177
						American Red Cross 733-6469		Alcoholics Anonymous (AA) 733-8300 (Hotline)
						Ryan White Title III HIV Clinic (Boise) 367-6030		Narcotics Anonymous (NA) 736-0918 1-800-444-1407
						College of Southern Idaho Student Health 733-9554 ext 2675		Cocaine Anonymous 429-3999

District 6

HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
Southeast District Health Department GLI with IDU women inmates ILI with MSM Testing 1901 Alvin Ricken Dr. Pocatello ID 83201 208-233-9080	Pocatello Family Medicine Ryan White Title III Clinic Pocatello, ID	Housing Authority of Pocatello 711 N. 6th Pocatello, ID 83201 233-6276	Community Access Program Pocatello, ID Dave Archuleta 478-3952 Suzy Buckskin Dir. 478-3866 Tyson Shay 478-3879	Department of Health and Welfare Medicaid Transportation	Dr. Martha Buitrago Pocatello, ID 208-535-4680	Southeast Idaho AIDS Coalition Carolyn Chaney RN 282-3171 239-5230	ISU Psychology Clinic Dr. Tony Cellucci Pocatello, ID 282-2129
NAACP Sista 2 Sista GLI HC/PI with African American, Outreach. Idaho Purce 208-232-8297	Southeast District Health Department HIV/AIDS Case Management 208-233-9080	Southeastern Idaho Community Action Housing Services Pocatello, ID	Idaho Food Bank 919 S Second Pocatello, ID 83201 233-8811	Ryan White Title II 239-5230	Bob's Pharmacy 500 S 11th Pocatello, ID 83201 208-239-1000 Fax 478-9172	Bannock County Indigent Fund Pocatello, ID 236-7347	LDS Social Services 1169 Call Creek Place Pocatello, ID 232-7780
Genesis Project GLIs with MSM Outreach with MSM Scott Tims 208-282-5312	Southeast Idaho AIDS Coalition www.seiac.com Contact: Leslee 208-522-0310	Aid for Friends Homeless Shelter 920 E. Clark Pocatello, ID 83201 232-0178	Bob's Pharmacy 500 N 11th Pocatello ID 83201 208-239-1179		SU HIV Clinic Dr. David Hachey Pharm.D. HIV Specialist 208-282-4700 Carolyn Chaney RN Nurse Case Manager 1901 Alvin Ricken Drive Pocatello, ID 83201 208-239-5230 cchaney@phd6.state.id.us Fax 208-234-7169	Idaho Migrant Council 60 Cedar Blackfoot, ID 83221 785-6390	Support Group Information Carolyn Chaney RN 239-5230 Dr. Tony Cellucci 282-2129
HIV Positive Support Group 282-2129	Occupational Safety And Health Administration (OSHA) www.osha.gov	Family Service Alliance, Emergency Shelter for Abuse Victims 232-4407	Super Save Drug 6th S Second Pocatello ID 83201 233-3342		VA Hospital 500 Foothill Blvd. Salt Lake City, Utah 84148 800-613-4012	Idaho Domestic Violence Programs 24 hour hotline 1-800-291-0463	Walker Center Substance Abuse TX 1-800-227-4190
W.I.S.E. Project GLI with Women at-Risk/IDU HC/PI with Women At-Risk/IDU Jill Hedt 208-282-5794	Southeast District Health Dept. Program Contact Jack Bennett 239-5242 jbennett@phd6	Housing Opportunities for People Living With AIDS HOPWA Contact: Carolyn Chaney RN 239-5230	Idaho Community Action Program		Not-tsoo-gah-nee-Health Center For Federally Recognized Native Americans Fort Hall Reservation 238-2400	Idaho Department of Labor Job Service 430 N. 5th. Pocatello ID 83201 208-236-6710	Alcoholics Anonymous 235-2444

District 6

HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
	Gay Men's Health Crisis www.cdcnpin.org	Bingham Crisis Center 823 West Bridge Blackfoot ID 83221	St. Vincent de Paul Portneuf Valley 336 N Main Pocatello ID 83201 208-233-2555		Pocatello Family Dentistry 465 Memorial Drive Pocatello, ID 83201 208-282-6000	Idaho Human Rights Commission 208-334-2873	Al Anon 235-2494
	HIV Positive Heterosexual Support Site www.postivecommections.org	HOPWA 1901 Alvin Ricken Dr. Pocatello ID 83221	St. Vincent de Paul 206 S Spruce Blackfoot ID 83201		Dr. Clay Campbell 166 South 5th Montpelier ID 83254	Franklin County Indigent Fund Preston ID 852-1090	Road To Recovery Substance Abuse 600 E Oak Pocatello ID 83201 233-9135+ Blackfoot Office 785-6688
	National Pediatric And Family HIV Resource Center www.pedhivaids.org	Idaho Housing and Finance 390 W. Sunnyside Idaho Falls ID 83404 522-6002 PO Box 7899 565 W Myrtle Boise ID 89707 877-438-4472	WIC Program Pregnant and Children 1901 Alvin Ricken Dr. Pocatello ID 83201 233-9080		Portneuf Medical Center 651 Memorial Dr Pocatello ID 83201 208-239-1000	LDS Employment Center 580 Roosevelt Pocatello ID 83201 232-2862	Addiction Counseling Pocatello ID 234-2512 Bannock, Power. Caribou Counties 233-9135
	Center for Positive Connections 888-POS-CONN 767-2666	Road to Recovery Housing Bingham County 785-6688	SEICCA USDA Food Commodities Distribution Third Week of each month in seven counties 233-7348		Family Practice Health West. Inc. Pocatello 232-6260 Lava Hot Springs 776-5202 Aberdeen 397-4127 American Falls 226-2822 Downey 897-5600	US Social Security Administration 1-800-772-1213 637-2532 TTY 637-2537	Counseling Associates 850 E. Center Pocatello ID 83204 232-8840
	ISU HIV Clinic 465 Memorial Drive Pocatello ID 83201 Contact: Dave Hachey Pharm. D 208-282-4700 Carolyn Chaney RN 208-239-5230	SEICCA Housing Services 825 E Bridger Pocatello ID 83201 234-0966	Food Stamps 1090 Hiline Pocatello ID 83201 235-2900		University of Utah Infectious Disease Clinic Dr. Kristen Reese 50 North Medical Salt Lake City Utah 801-585-2031 Dr. Andrew Pavia 801-581-6791	Consumer Credit Management Service 888-455-0200	Center for New Directions Career and Transition Counseling Pocatello ID ISU Campus 282-2454

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 6		Massage Therapy And Acupressure Conant Golden Eagle 232-5509	USDA Rural Development Home ownership loans for low income families 785-5840 ext 4			Pocatello Family Medicine Ryan White Title III Clinic 465 Memorial Drive Pocatello ID 83201 Fax 208-282-4696 208-282-4700	Bannock County Court Assistance Office 624 E Center Pocatello ID 83201 236-7067	Pocatello Family Medicine Dr. John Dickey 465 Memorial Dr. Pocatello ID 83201 282-4700
						Southeastern District Health Dept Department of Epidemiology Epidemiologist – Jeff Doerr Kathy Reynolds 208-233-9080 1901 Avin Ricken Drive Pocatello ID 83201 Fax 208-282-4696 208-282-4700	Co-Ad Inc. 845 W. Center Pocatello ID 832011- State Advocacy Program for Idahoans with disabilities 800-632-5125	J & M Mental Health Services 60 North Broadway Blackfoot ID 83221 208-782-3434
						Dr. John Fornorotto Eye Care 500 S 11th Pocatello ID 83201 234-4100	Idaho Legal Aid 150 S. Arthur Pocatello ID 83201 233-0079	Gay Men's Social/Outreach Group Genesis Project 282-5312
						Physician's Immediate Care Center 1246 Yellowstone Pocatello ID 83201 237-1122	ISU Financial AID Office 282-2756	Suicide Prevention Hotline 1-800-949-0057
						Shriner's Hospital Pediatric Orthopedics 1-801-874-2572	ISU Career Development Center 282-2380	Pocatello United Methodist Church Reverend Tom Tate 200 N 15th Pocatello ID 83201 232-3056

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 6						AIDS Clinical Trials Information 800-874-2572	Crime Victim Compensation Program 317 Main St. Boise ID 83702 800-950-2110	Emotional Support Meeting 232-5791
						Southeast Idaho Veteran's Outpatient Clinic 444 Hospital Way Pocatello ID 83201 232-6214	Idaho State Bar Association Ask for "lawyer referral service" Charge is $35.00 per 30 minutes of consultation. 1-208-334-4500	Adult Mental Health 234-7900
						AIDS Drug Assistance Program 208-334-5943	American Civil Liberties Union PO Box 1897 Boise ID 83701 208-344-5243	First United Congregational Church Reverend Janie Gebhardt 309 N. Garfield Pocatello ID 83201 232-3056
						Pocatello Family Dentistry 465 Memorial Drive Pocatello ID 83201 282-6000		Family Service Alliance Emergency Crisis Line-Domestic Violence 251-Help Victim's Compensation/Medicaid, Men's Non Violence Group, Anger Management Victim Support Services Group 355 S. Arthers Pocatello, ID 83204 232-0742
						Lab Corp. 232-6740 Fax 234-0130		Narcotics Anonymous 232-9565

						Pocatello Free Clinic 429 Washington Pocatello ID 83201 233-6245		

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 7	District 7 Health Department 254 E Street Idaho Falls ID 83402 GLI with IDU ILI with Persons at-Risk Outreach & HC/PI HIV Testing 522-0310 x135	Family Practice Ryan White Clinic Pocatello ID	The Haven Temporary Shelter Idaho Falls ID 523-6413	St. Mark's Episcopal Church 4th & S. Boulevard Idaho Falls ID	CART Idaho Falls ID	University of Utah 50 N Medical Drive Salt Lake City UT 84132 1-800-824-2073	St. Vincent di Paul Idaho Falls ID 522-6280	Counseling Services And support group information available upon request. Contact Leslee Martin at 522-0310x135
	Contact Leslee Martin HIV/AIDS Case Manager 254 E Street Idaho Falls ID 83402 District VII Health Dept 522-0310x135	District 7 Health Department HIV/AIDS Case Management 208-522-0310	City of Refuge Idaho Falls ID Ron Youderian Director 552-5575	Salvation Army 605 N. Boulevard Idaho Falls ID 83401-2240 522-7200	Eagle Rock Transport Idaho Falls ID 524-6212	VA Hospital 500 Foothill Blvd. Salt Lake City UT 84148 1-800-613-4012	Salvation Army Idaho Falls ID 522-7200	Region VII Mental Health 528-5700
	Challis 879-2504 St. Anthony 624-7585 Rigby 745-7297 Salmon 756-2123 Rexburg 356-3239 Driggs 354-2220	Southeast Idaho AIDS Coalition 236-3171	Idaho Housing Agency 522-6002	St. John's Episcopal Church 270 N Placer Idaho Falls ID 83402-4021		Idaho Falls Regional Medical Center	Idaho Falls Health & Welfare 528-5800 Bonneville County 529-1385 Jefferson County 734-9223	
	Southeast District Health Department (Pocatello) 233-0980	HIV Support Groups	Housing Opportunities for Persons With AIDS (HOPWA) 877-438-4472	Gleaners Idaho Falls ID Contact, Ray 522-1402		Southeast Family Practice	Madison County 356-3662 Rexburg 356-9218	
	Southeast Idaho AIDS Coalition 236-3171	PFLAG (Kay) Idaho Falls ID 529-8945		Living Waters Christian Church Bread Ministry 775 Lincoln Drive Idaho Falls ID 83401-4920		Dr. Barry Bennett 2775 Channing Way Idaho Fall ID 83404-751 524-0134	Social Security Office 522-7992 800-772-1213 TTY 522-7516	

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 7	American Red Cross 522-8262	AIDS Drug Assistance Program 334-5943		Eastern Idaho Special Services Agency Idaho Falls ID		Dr. Leland Krantz 2001 S Woodruff Idaho Falls ID 83404 522-7310	Idaho Legal Aid 524-3360	
	PFLAG (Kay) 529-8945	District 7 Health Dept Program Contact: Tamara Cox tcox@phd7 522-0310				Dr. Brent Mueller 2860 Channing Ste. 111 Idaho Falls ID 83404 535-4044	Idaho STD/AIDS Program 450 W. State 4th FL. Boise ID 83720 AIDS Drug Assistance Program – 334-5943 Direct Care Services 334-6657	
						Title III Clinic ISU Family Practice Residency 365 Memorial Drive Pocatello ID 83404 208-282-4700		
						Eagle Rock Dental Care 640 S Woodruff Ave Idaho Falls ID 83401-5299 523-5400		

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 7						Dr. Mark Tall Sandcreek Dental 2460 E 25th St. Idaho Falls ID 83404-7549 524-4780		
						Dentist Dr. David Henninger 1400 East 17th Idaho Falls ID 83404-6269 524-1700		
						Dr. H. Keith Couch 2100 East 25th St. Idaho Falls ID 83404-6475 524-2300		
						Steven Fredrickson DDS Chair, Dept of Dental Services ISU Pocatello ID 83209 208-282-3289		
						Eye Care Dr. Scott Homer ShopKo Optical 800 East 17th Street Idaho Falls ID 83404-6151 522-6271		

	HIV Prevention Interventions	HIV/AIDS (General)	Housing	Nutrition	Transportation	Medical/Dental	Financial/Legal	Mental Health/ Substance Abuse
District 7						Eye Care Dr. Gary Lattimore 501 South Woodruff Idaho Falls ID 83401-5200 522-6271		
						Dr Gary Lattimore 47 South Main Driggs ID 83422 Dr. Lattimore is servicing Victor and Tetonia. 354-8304		
						Eye Care Dr. Darren Hatch Rexburg Vision Center 49 East 1st South Rexburg ID 83440-1966 356-4444		

Gap Analysis of Idaho's HIV Prevention Services

In May 2003, the ICPC Gap Analysis Committee conducted an analysis of the HIV prevention services offered in Idaho as compared to the prevention needs of the state's three priority populations.

In completing these tasks, the committee first looked at other states' gap analysis models, and decided on a process and format. They used ICPC needs assessment data of men who have sex with men, women at-risk and IDUs. The 2003 ICPC Resource Inventory was also used to compare needs to services that exist. Additional gaps noted were based on past ICPC meeting minutes and state STD/AIDS conference proceedings.

The Gap Analysis was first given to the ICPC Prevention Intervention Committee for use in developing intervention recommendations for the ICPC to consider. The Gap Analysis was then presented to the ICPC at its July 2003 meeting, and was used as a data source in prioritizing populations and selecting prevention interventions.

The Gap Analysis Committee is currently working on a new analysis of gaps in prevention services to MSMs, including those who are HIV+.

Gap Analysis of Idaho's HIV Prevention Services - 2003

Prevention Issues of Men Who Have Sex With Men	HIV Prevention Gaps Affecting these Issues
The majority of MSM are not using condoms during risky sexual behaviors *(MSM Needs Assessment)*	✓ Prevention interventions need to address the reasons cited by MSM for not using condoms: partner reaction, interference with personal pleasure, and HIV status of the respondent and the partner, and be based on sound behavior change theory.
An even greater majority of MSM under age 21 are not using condoms during risky sexual behaviors *(MSM Needs Assessment)*	✓ Interventions for young MSM need to build community norms that support safer sex behaviors.
MSM report significant barriers to being tested for HIV *(MSM Needs Assessment)*	✓ Testing and counseling services need to respond to MSM concerns about fear, waiting, and anonymity. These may include rapid testing and more non-traditional testing sites.
Rural MSM are challenged by lack of an accessible, supportive community; are put at risk by traveling to cities for sex; face isolation; and have poor access to health care. *(MSM Rural Focus Groups)*	✓ Idaho currently has prevention interventions tailored to rural MSM in north and south east Idaho. These types of models do not exist in other large rural areas of the state: north central, southwest, south central and eastern Idaho.
MSM report knowing about, yet not acknowledging HIV *(MSM Rural Focus Groups; North Idaho Gay Men's Health Retreats)*	✓ Interventions need to take into account the whole of an MSM's life, and not just deliver prevention information in isolation of other health, relationship, social and economic issues and dynamics.
Nine percent of Idaho MSM diagnosed with HIV over the past 10 years were of Hispanic ethnicity. Hispanic men report lack of accessibility to testing, condoms, and knowledge about HIV. *(2002 Epi Profile; Interviews with Idaho Hispanic Agricultural Workers, 2002)*	✓ There has been only one intervention targeted to reach Hispanic persons in Idaho – an effort to reach students at College of Southern Idaho. The Hispanic migrant and settled community stretches across the whole of southern Idaho, with a small population in north Idaho as well. Hispanic community representatives need to be engaged in planning and implementing culturally appropriate interventions.

Prevention Issues of Women at-Risk	HIV Prevention Gaps Affecting these Issues
Women are not aware they are potentially at risk *(Women at Risk Needs Assessment)*	✓ There are group level interventions reaching women in Coeur d'Alene, Caldwell, Boise, Pocatello, and Idaho Falls; however, these are limited in their settings and resources to reach women unaware of their risks. The interventions take place in prisons, a mental health residential treatment home, domestic violence shelters, and a college campus. ✓ There are few interventions reaching women outside of the five Idaho cities listed above. *(ICPC Resource Inventory of HIV Care and Prevention Services)*
Women with known risks are not using condoms *(Women at Risk Needs Assessment)*	✓ Individual and group interventions need to address risk awareness, efficacy skills, partner negotiation, and self esteem. *(Compendium of HIV Prevention Interventions with Evidence of Effectiveness, CDC)*
Women at risk are not getting tested for HIV *(Women at Risk Needs Assessment)*	✓ HIV testing should be included in other health care screening visits. ✓ Health care providers need increased awareness of women at risk of HIV infection. ✓ Testing sites need to respond to women's barriers of fear, cost, waiting, anonymity. ✓ Women need more education about getting tested due to potential risks.

Prevention Issues of Injection Drug Users	HIV Prevention Gaps Affecting these Issues
IDUs report significant levels of the risk behaviors of needle sharing and unprotected sex *(IDU Needs Assessment)*	✓ There are IDU individual level and group level interventions in 6 of Idaho's 7 health districts. Though they effectively target the high risk behaviors of these persons, they are limited in their scope and resources to reach many in this population. *(2003 Resource Inventory of HIV Care and Prevention Services)*
IDUs have difficulty acquiring clean needles from a safe source. *(IDU Needs Assessment)*	✓ Idaho pharmacists need to better understand the importance of IDUs having access to sterile syringes through pharmacy sales. *(ICPC's former IDU Committee findings, 2001; Idaho STD/AIDS Conference Panel, 2001; Journal of the American Pharmaceutical Association, Nov./Dec. 2002)* ✓ Idaho needle exchange laws are incongruent with proven IDU harm reduction strategies *(Idaho Code; Principles of HIV Prevention in Drug-Using Populations, NIDA)*
IDUs have difficulty addressing other major life issues, such as housing, employment, family, health care services, etc. (*IDU Needs Assessment)*	✓ Idaho's policy makers and health care providers do not see IDU as a health issue, but a legal/moral issue. ✓ Prevention providers need a deeper understanding of the interconnected risks for IDUs: mental illness, STDs, domestic violence, homelessness, poverty, etc. ✓ Prevention efforts need to better coordinate efforts with the mental health, substance abuse, and corrections systems. ✓ Coordinated prevention and treatment efforts need to incorporate a harm reduction approach. *(Recommendations of the ICPC's former IDU Committee; Principles of HIV Prevention in Drug-Using Populations, NIDA; A Comprehensive Approach: Preventing Blood-Borne Infections Among Injection Drug Users, CDC)*
IDUs need to be tested for their HIV status *(IDU Needs Assessment)*	✓ Testing and counseling sites need to assess and address barriers to IDUs being tested for HIV. ✓ There is little outreach to IDUs outside of treatment and corrections systems.

PRIORITIZED TARGET POPULATIONS

Idaho's 2004-2006 priority populations for HIV prevention resources are ranked as follows:

1. **Persons Living with HIV/AIDS.**
2. **Men Who Have Sex With Men**: A man who has sex with another man, or a man who reports sexual contact with both men and women, whether or not he identifies as gay.
3. **High Risk Heterosexual**: A birth sex male who has sex with a woman, or a birth sex female who has sex with a male, with one or more of these risk factors present: the partner is either an IDU, MSM, or HIV+ person; the person had sex in exchange for drugs or money; the person has an STD diagnosis; or the person has had multiple sex partners.
4. **Injection Drug User**: A person who uses a needle or syringe to inject drugs.
5. **Youth**: A person 13-24 years of age who engages in sex and/or uses needles.

How Idaho's High Risk Populations were Prioritized

In July 2003, the ICPC met to prioritize Idaho's populations most at risk of HIV infection and most in need of prevention services. The goal was to rank populations with the highest incidence of HIV infection and on which prevention efforts would have the greatest impact. The ICPC used a prioritization process based on an Academy for Educational Development (AED) technical assistance guide. Seven steps were used:

1. Identify and define potential populations.
2. Determine factors to rate the populations.
3. Weight each factor.
4. Rate each population using the factors.
5. Score each population using the factors.
6. Rank the populations using the scores.
7. Review and adjust the final prioritized list as needed.

Further description of how the ICPC proceeded through each prioritization step is provided below:

Step 1. It was first clarified that HIV+ persons were mandated by the CDC to be the top ranked priority population. To assist in identifying other populations, ICPC members were provided summaries of the epi profile, resource inventory, gap analysis, and needs assessment results (full reports had been provided in previous meetings).

The ICPC discussed whether to define a population by demographics or risk behaviors, or both. The Council identified four populations, and decided to add further definition after rating and scoring them. The four populations were:

- IDU
- High Risk Heterosexual (HRH)
- MSM
- Youth

Steps 2 and 3. The factors used to rate the populations were based on the AED manual. An ad hoc committee of the ICPC weighted the factors prior to the meeting. ICPC members were provided worksheets with the factors and weights. They included:

Factor	Weight
• AIDS Incidence	3
• HIV Incidence	5
• HIV/AIDS Mortality	2
• HIV/AIDS Prevalence	5
• Key indicators of risk behavior	4
• Riskiness of population behaviors	5
• Difficulty in meeting population needs	5
• Barriers to reaching the population.	5

Steps 4, 5, and 6. ICPC members divided into small groups and were each given one priority population to rate and score. Members chose groups that did not represent a conflict of interest to them. The groups used epi, needs assessment, and gap analysis data to determine their ratings.

Each group then reported their experience in the rating process and their final score to the full ICPC. All groups agreed they did not have enough information to rank frequency of risk behavior, so that factor was eliminated from the scoring. The ICPC recommended that this type of data be addressed in future needs assessments. The MSM population group pointed out that the needs assessment data it had only reflected gay men, not non-gay identified MSM. Also, the HRH group cited that they only had needs assessment information for women at-risk. The youth group saw that, while the CDC definition of youth is 13-24, most infections were occurring in ages 19-24.

The population scores and ranks were:

Population	Score	Rank
Persons living with HIV/AIDS	n/a*	1
MSM	96	2
[HRT]Supposed to be HRH?	94	3
IDU	76	4
Youth	51.5	5

** The HIV+ population was not scored, as it was pre-determined to be the top priority population.*

The ICPC broke back into small groups with the task of each group to provide a definition for one priority population. The definitions were then presented to the full ICPC for discussion. There was debate about how to best, or whether to, incorporate risk behaviors into each priority population's definition. There was also discussion on how to best clearly define what each risk behavior was. The final definitions are provided at the beginning of this plan section.

Step 7. The ICPC then reviewed all the priority populations and their rankings. One member expressed her concern that youth was at the bottom of the ranking. Other members responded that youth will also be reached in interventions to the other priority populations. Also, non-STD/AIDS funded prevention programs will also reach youth in Idaho, such as the Idaho Department of Education's efforts.

The populations and rankings were approved unanimously.

Recommended HIV Prevention Interventions

In July 2003, the ICPC recommended a set of prevention interventions for each priority population. To make these decisions, the group was presented with the following data on Idaho's current interventions:

- Name of the intervention.
- Population reached.
- Why the intervention is appropriate for and acceptable to this population.
- Why the intervention is feasible to do in that particular region of Idaho.
- What behavioral change or social theory the intervention is based on.
- Any evaluation outcomes that have been collected on the intervention.
- Any other comments on why the intervention is successful and/or should continue.

In addition, the ICPC used the priority population needs assessments, resource inventory, gap analysis, national studies on effective interventions, and specific interventions researched by the ICPC Prevention Intervention Committee.

The ICPC broke into working groups, with each group selecting interventions for a priority population. The youth priority population was addressed as part of the other four populations: HIV+, MSM, HRH, and IDU. The task of each group was to identify types of interventions and cite justifications for their selection. The groups then presented their recommendations to the full ICPC.

In June 2004, the ICPC decided to delay updates to MSM interventions until the recent needs assessment survey could be further studied, and the MSM gap analysis completed.

There are minor updates to the IDU interventions, to better reflect current prevention work occurring in Idaho.

Recommended Prevention Interventions
Persons Living with HIV/AIDS

HIV+ Intervention	Appropriateness to HIV+ Persons	Feasibility	Behavioral Change/Social Theory Basis	Evidence of Effectiveness
Prevention Case Management	This intervention is tailored to personal risk factors, harm reduction to self and others, and support, both individualized and for partners. Reports from the Rural Center from AIDS/STD Prevention and the National Institute of Mental Health indicate that rural persons living with HIV/AIDS are more likely to continue having unprotected sex than those in urban areas, and experience more complex mental health issues.	A number of prevention and care providers have been trained in PCM, and are offering the service. Idaho follows CDC Prevention Case Management Standards and Guidance.	Adopting and maintaining HIV risk-reduction behaviors based on a stages of change theory.	PCM is a highly intensive individual level intervention with a case management component. ILIs have shown to be effective in changing risk behaviors in a variety of populations. Idaho's PCM providers collect data on the delivery and outcomes of their services to HIV+ individuals.
Positive Power	Offers HIV+ persons a flexible and focused program of inquiry, challenge and support that impacts their ability to engage in safer sex behavior.	The Idaho STD/AIDS Program is training HIV/AIDS care workers statewide on implementing this intervention.	Stages of change and relapse prevention theory.	This model has been successfully implemented in the state of Washington
Testing, Counseling and Referral	This service is intended to reach those living with HIV who don't know their status.	Rapid HIV tests, non-traditional testing sites, quality counseling, and incorporating testing into other medical settings will make this service more accessible.		This activity addresses CDC's goal of increasing the proportion of HIV-infected persons who know they are infected.

HIV+ Intervention	Appropriateness to HIV+ Persons	Feasibility	Behavioral Change/Social Theory Basis	Evidence of Effectiveness
Group Level Interventions, such as the existing *Positive Living* support group in north Idaho, and *Support for Me … Support for Others* group in north central Idaho	There have been consistent requests for HIV+ support groups in Idaho. Current participants report learning new information and feeling that the groups are a safe opportunity to talk with other HIV positive persons about reducing one's high risk activities. The groups work because they are based on empowering self and others to make choices which will give strength to relationships and not endanger self or others. They are a needed source of support for rural, isolated persons living with HIV/AIDS	All who have participated have returned for additional sessions. There has been 100% retention of group members. With a small number of HIV positive persons in rural Idaho, reaching those infected through a safe environment for meaningful discussion appears to be very feasible.	Cognitive behavioral model with trans theoretical of stages of change.	*Positive Living* is collecting pre/post tests, but they have not been analyzed yet. In north central Idaho, all those who have attended at least 6 sessions indicate on a measurement tool that they: a) will not have sex without a condom or share needles; b) have told all partners, and will inform all potential partners of HIV status; and c) acknowledge and accept responsibility to not infect others.
Health Communications/ Public Information addressing persons living with HIV/AIDS	This is a proposed targeted media campaign with two goals: 1) to promote compassion for persons living with HIV, thus reducing their isolation and potential risk behaviors, and 2) to bring HIV+ persons into care and prevention services.	Persons living with or affected by HIV/AIDS, as well as known Idaho figures, would deliver personal messages about HIV prevention, the importance of testing, and the experience of having HIV/AIDS.	Theories of peer influence and diffusion of innovations.	CDC's *Consultation on Rural HIV Prevention for MSM* has recommended that in order to do effective prevention, states should use strategies to address social homophobia - a major reason HIV+ persons in Idaho remain hidden.

Recommended Prevention Interventions
Men Who Have Sex With Men

MSM Intervention	Appropriateness to MSM	Feasibility	Behavioral Change/Social Theory Basis	Evidence of Effectiveness
Mpowerment Model	In Boise (BOI O BOI) and Pocatello (Genesis Project), young MSM are planning and participating in adaptations of this intervention. The project builds self-esteem and a supportive safe environment, which in-turn, empowers positive peer influence and encourages community. These elements help extinguish barriers to HIV transmission.	The various Mpowerment components – formal and informal outreach, small groups, and targeted publicity campaigns - have been well accepted in both urban and rural Idaho. Web sites have proven to be useful tools in outreach as well.	Peer influence, diffusion of innovation, and community organizing.	Mpowerment is included in the CDC's *Compendium of HIV Prevention Interventions with Evidence of Effectiveness.*
Group Level Interventions for Incarcerated Men	In north central Idaho, a *Step Back … Move Ahead* project helps MSM plan for risk reduction during and after incarceration. The intervention has been well-received by participants, who voluntarily attend. The group provides a venue for discussion about choices they may have made, and goals to make more healthy choices in the future.	Both prison staff and inmates have been very receptive to this group level activity. Giving the inmates a solid foundation of HIV prevention knowledge helps them to understand the potential outcome of risky behaviors.	The health belief model of behavior change, which stands on the principle of acknowledged risk and self-determination of risk.	A north central Idaho pre/post test has found that participants demonstrated an increased knowledge about HIV, and willingness to change behavior, especially in the use of condoms upon release from prison.

MSM Intervention	Appropriateness to MSM	Feasibility	Behavioral Change/Social Theory Basis	Evidence of Effectiveness
MSM Health Retreats	MSM retreats held in north and east Idaho were highly rated by participants. The intervention allows gay men to discuss and learn about health, sexuality, HIV and life issues in a safe and supportive environment. MSM plan the agenda, organize the events, and facilitate the discussions.	This has proven to be a feasible intervention to organize for rural gay men. It offers a rare opportunity for rural MSMS to connect, learn and support one another.	Social cognitive theory and theory of reasoned action.	CDC's *Consultation on Rural HIV Prevention for MSM* has identified retreats as a promising rural-based intervention to build community. The CDC has identified the University of Minnesota's *Man-to-Man-Sexual Health Seminar* as a scientifically valid and theoretically sound intervention.
Group Level Interventions for Rural MSM	There are group level interventions for MSM currently in north and north central Idaho (in addition to Mpowerment groups in Boise and southeast Idaho). They offer a safe and enjoyable way to discuss HIV/AIDS education and prevention. The groups continue to be innovative and address the whole individual, which allows for each person to better incorporate safer behaviors in their lives. Participants, in-turn, become role models for their peers.	The groups have been very well received by gay, bi-, and questioning men. Attendance has been strong, and participants are getting their peers involved.	Stages of change and social learning theories.	Participants in north central Idaho reported that the groups helped them make safer behavior choices. Evaluation results for north Idaho are pending. Several studies document behavior change through group interventions: "A Randomized Controlled Intervention Trial of Sexual Health Approach to Long-Term HIV Risk Reduction for Men who Have Sex with Men:" and the "Sexual Health Model: Application of Sexological Approach to HIV Prevention."

MSM Intervention	Appropriateness to MSM	Feasibility	Behavioral Change/Social Theory Basis	Evidence of Effectiveness
Outreach to Hispanic MSM	Hispanic MSM need to be reached through their own cultural venues and connections. These include *promotora*, fotonovela, and Spanish media. Prevention workers who are not part of Idaho's Hispanic communities also need to be trained in culturally appropriate ways to reach and involve Hispanic persons in planning and carrying out interventions. The American Red Cross *Hispanic HIV/AIDS Program*, which includes an *HIV Education and Prevention Instructor Course*, may be a useful tool.	Although Idaho's total population is 8% Hispanic, there are numerous rural communities throughout southern Idaho with Hispanic populations exceeding 25%. Formal and informal networks exist to reach these communities with HIV prevention interventions. It will require an approach that fits with the communities' culture, beliefs and attitudes. The ICPC also needs to engage more Hispanic persons in community planning, using guidance from *The State of Latinos in HIV Community Planning* publication.	Diffusion of innovations	

Recommended Prevention Interventions
High Risk Heterosexuals

Intervention	Appropriateness to HRHs	Feasibility	Behavioral Change/Social Theory Basis	Evidence of Effectiveness
Outreach and Health Communication/ Public Information	ICPC recommends these two intervention components to reach HRHs who may benefit from group and individual level intervention services, and to build this population's awareness of HIV prevention risks and prevention services. HRHs need to be reached in the community, and "where they're at" with their lives.	Outreach and HC/PI strategies are typically built into Idaho's prevention providers' plans. Idaho smaller cities and towns offer ease in collaboration with other community organizations and groups to creatively partner in outreach and education efforts.	Diffusion of innovations, community mobilization	Idaho prevention providers have successfully worked with community action agencies, health clinics, shelters, residential treatment facilities, juvenile corrections, and other entities to obtain referrals for prevention services, and to provide outlets for HIV education and information.
Individual Level Interventions	Individual counseling provides a viable way to work on self-empowerment, partner negotiation skills, condom use, and reduction of other risk behaviors. The intervention can also provide referrals to other needed health and community services. Individual counseling is also appropriate for HIV- partners of HIV+ persons, as it provides them knowledge, resources and support to remain uninfected.	HRHs can be reached through STD clinics, corrections, substance abuse treatment centers, social service agencies, and health care providers. The outreach component described above will also help identify HRHs. Idaho has prevention providers statewide trained in client centered counseling to offer this service.	Stages of change theory, and theory of reasoned action	The *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* cites a counseling intervention, *Project RESPECT*, which impacted condom use and new STD diagnoses.

Intervention	Appropriateness to HRHs	Feasibility	Behavioral Change/Social Theory Basis	Evidence of Effectiveness
Group Level Interventions	There are eight group level interventions currently reaching HRHs in Idaho: three are based on the *Sister-to-Sister* model – one reaching Black women in southeast Idaho, one reaching urban women in Boise, and one working at a residential home for women with mental illness and substance abuse. Two interventions are occurring in prison settings, two in domestic violence shelters, and one on a university campus. All have adapted their tools, formats, and information to respond to the unique circumstances of these women.	Organizations throughout Idaho have been very receptive to including HIV prevention groups in their services. The women themselves highly rate their participation in the groups.	Empowerment theory, theory of social learning	*Sister-to-Sister* is a nationally recognized and accepted intervention for women. The two prison groups are collecting data on knowledge, attitude, and behavior change through pre- and post-surveys and post-release follow-up. 2002 results indicated a significant change in participants' knowledge, attitudes and beliefs.

Recommended Prevention Interventions
Injection Drug Users

Intervention	Appropriateness to IDUs	Feasibility	Behavioral Change/Social Theory Basis	Evidence of Effectiveness
Peer Outreach	These activities provide a means to reach IDUs who are not in treatment or corrections programs. Peers can influence the IDU's community norms about risk reduction, and encourage IDUs to seek HIV testing and treatment for drug use. Peers can offer a respectful, trusted approach to individuals in need of prevention services.	This intervention has not been done yet in Idaho; however, a peer outreach mentor who is a member of the ICPC is seeking support for implementation in eastern Idaho. Although peer outreach is acknowledged as a component of a comprehensive HIV prevention program for IDUs, it has its recognized challenges such as recruiting, training and supporting the peer workers.	Social cognitive theory	Peer opinion leaders have shown to be effective in reducing the sharing of injection equipment. Peer outreach workers have also proven to be effective in referring IDUs to treatment. *(National Institute on Drug Abuse)* Studies have also shown IDUs reported reductions in five major risk behaviors after participating in community outreach interventions. *(CDC, A Comprehensive Approach: Preventing Blood-Borne Infections Among Injection Drug Users)*

Intervention	Appropriateness to IDUs	Feasibility	Behavioral Change/Social Theory Basis	Evidence of Effectiveness
Group Level Interventions	Small group interventions with IDUs are currently being conducted in three prison settings, three residential treatment facilities, and a drug court. The programs are designed to increase motivation for behavior change, teach skills to reduce risk (with both drug use and sexual behaviors), and reinforce positive behavior change.	Community organizations that reach IDUs are very receptive to incorporating HIV prevention strategies into their services.	Empowerment theory, theory of social learning	Several group level interventions with IDUs in CDC's *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* have similar components in their group content: learning about HIV/AIDS, defining their risks, building skills to reduce risks, and reinforcing behavior change.
HC/PI directed at pharmacists on knowledge and application of state laws regarding sale of needles and syringes.	Access to clean needles is key to prevention of HIV transmission among active IDUs. Pharmacists can be a viable source for clean needles.	The Idaho STD/AIDS Program has contracted with Idaho State University to provide training on the importance of clean needle access to retail pharmacies and pharmacy students. ISU is also assessing the HIV training needs of pharmacy students, Idaho retail pharmacies' policies on clean needle sales, and other states' models of clean needle exchange programs.		The American Medical Association, American Pharmaceutical Association, and other national associations issued a joint statement urging state leaders in medicine, pharmacy, and public health to coordinate action to improve IDU's access to sterile syringes through pharmacy sales. *(CDC, A Comprehensive Approach: Preventing Blood-Borne Infections Among Injection Drug Users)*

Meeting CDC's HIV Prevention Community Planning Goals and Objectives

Introduction

The Centers for Disease Control and Prevention published a new guidance for HIV Prevention Community Planning in July 2003. The guidance help states and community planning groups measure how well they are meeting the goals and objectives of community planning. There are two types of measures: Program Performance Indicators and Critical Community Planning Attributes. Idaho's performance is detailed below.

Program Performance Indicators

Indicator 1
Proportion of populations most at risk, as documented in the epidemiologic profile, that have at least one ICPC member that reflects the perspective of each population.

Idaho's epidemiologic profile documents three populations listed below to be most at risk of HIV infection.[1] There are 741 persons living with HIV/AIDS in Idaho. The most prevalent known modes of exposure are:

- Men who have sex with men (MSM) 45%
- Injection drug users (IDU) 16%
- Heterosexual contact 15%

The ICPC has all three at-risk populations represented in its membership:

- MSM (6)
- IDU (1)
- High Risk Heterosexual (3)

Idaho's performance indicator is **100 percent** of populations most at risk represented. It is also noted that the ICPC has four members who are living with HIV/AIDS, also a priority population.

[1] Other population prevalence percentages are each less than eight percent: adult hemophiliac, transfusion/ transplant, and all pediatric surveillance categories. The "Other/Risk Not Specified" category represent 12 percent of persons living with HIV/AIDS.

Indicator 2
Proportion of key attributes of an HIV prevention community planning process that ICPC membership agreed have occurred.

ICPC members completed a Community Planning Membership Survey at their June 2004 meeting. They provided a response of "agree," "disagree," or "don't know" for questions about CDC's community planning Objectives A – H. Agree and disagree (valid) responses were totaled for these questions. There were 734 valid responses, with 661 "agrees" and 73 "disagrees." The proportion of responses that agreed key attributes of community planning occurred was **90 percent**.

The Community Planning Membership Survey Report attached as Appendix B provides a breakout of agreement percentages for each community planning objective.

Indicator 3
Percent of prevention interventions/supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan.

All of the prevention interventions included in the Idaho STD/AIDS Program's CDC funding application are specified as a priority in the 2004-2006 Idaho HIV Prevention Comprehensive Plan, **100 percent**.

Indicator 4
Percent of health department-funded prevention interventions/supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.

All STD/AIDS Program-funded prevention interventions in Idaho correspond to priorities specified in the 2004-2006 Idaho HIV Prevention Comprehensive Plan, **100 percent**.

Critical Community Planning Attributes

Goal One
Community planning supports broad-based community participation in HIV prevention planning.

Objective A	Indicator
Implement an open recruitment process (outreach, nominations, and selection) for ICPC membership.	Idaho HIV Care and Prevention Council (ICPC) members completed the Community Planning Membership Survey in June 2004. Results indicate the following: ✓ 93 percent agreed that the ICPC has written procedures for nominations to the ICPC. 7 percent disagreed. ✓ 93 percent agreed that the ICPC uses these written procedures for nominations to the ICPC. 7 percent disagreed. ✓ 93 percent agreed that the ICPC has established a nominations committee. 7 percent disagreed. ✓ 100 percent agreed that nominations target membership gaps identified by the members of the ICPC. ✓ 93 percent agreed that ICPC membership decisions involve more than the health department staff. 7 percent disagreed. ✓ 100 percent agreed that the ICPC has written documentation of the process for selection of ICPC members. ✓ 100 percent agreed that the ICPC uses this process in the selection of ICPC members.

Objective B	Indicator
Ensure that the ICPC's membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the state, and includes key professional expertise and representation from key governmental and non-governmental agencies.	June 2004 Community Planning Membership Survey results indicate that the ICPC membership has the following diversity of members. (A *Community Planning Membership Survey Report* is provided in Appendix B.) 6 MSM 0 MSM/IDU 1 IDU 2 Unsafe heterosexual sex 0 Women at risk for transmitting HIV during pregnancy/birth 4 HIV positive Age 0 <19 — 13 30-49 1 20-24 — 7 50+ 3 25-29 Gender 10 Male — 0 Transgender 14 Female *82 percent of persons living with HIV/AIDS in Idaho are male and 18 percent are female.* Sexual orientation 14 Heterosexual — 0 Bisexual man 6 Gay man — 1 Bisexual woman 3 Lesbian Race 0 American Indian or Alaska Native 0 Asian 3 Black or African American 0 Native Hawaiian or Pacific Islander 21 White

Ethnicity

1 Hispanic or Latino
23 Non-Hispanic or Latino

The ICPC membership also includes these categories of professional expertise and governmental and non-governmental agencies:*

0 Epidemiologist (but available to the ICPC)
2 Behavioral or social scientist
1 Evaluation researcher
2 Intervention specialist
3 Health planner
8 Community representative
0 Substance abuse
0 Mental health
2 Health department
12 HIV prevention or care services provider
1 State/local education agencies
2 Academic institution
0 Faith community

* Totals more than 24 as several members bring more than one type of expertise.

Objective C	Indicator
Foster a community planning process that encourages inclusion and parity among community planning members.	✓ June 2004 Community Planning Membership Survey results indicate that 91 percent of the members agreed that the planning process encourages inclusion and parity among ICPC members. 9 percent disagreed. ✓ All new ICPC members receive a two hour orientation from the Co-Chairs and STD/AIDS Program, as well as an orientation guide and member manual. ICPC leadership meets with new members after their first full meeting to respond to questions and obtain feedback. ✓ Written conflict of interest policies are followed, with each member disclosing potential conflict of interest annually in writing, and before voting. ✓ All ICPC members serve on one of five working committees, allowing them further opportunity to participate in the community planning process. ✓ ICPC members provide suggestions for training and technical assistance at each meeting. The STD/AIDS Program then arranges for speakers, materials and other resources as needed to address these suggestions. ✓ ICPC meeting discussions and decisions are led by a neutral facilitator who uses techniques that ensure participation by all members. ✓ ICPC Co-Chairs attend the annual HIV Prevention Leadership Summit. ✓ The ICPC Administrative Committee follows up with all members absent from meetings to ensure there are no accommodation barriers preventing their participation.

Goal Two
Community planning identifies priority HIV prevention needs, including priority populations and interventions for each population.

Objective D	Indicator
Carry out a logical, evidence-based process to determine the highest priority, population specific prevention needs in the state.	✓ June 2004 Community Planning Membership Survey results indicate that 84 percent of ICPC members agreed that a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the state was carried out. 16 percent disagreed. ✓ Idaho's Epidemiologic Profile, contained in this Plan, provides information about populations at high risk for infection, discusses the strengths and limitations of its data sources, identifies data gaps, and contains a narrative interpretation of the data. ✓ The Epidemiologic Profile was presented to the ICPC at its January 2003 meeting. Epi data was provided again at the July 2003 meeting when populations were prioritized and prevention interventions were selected. Epi updates were provided at 2004 meetings. ✓ A needs assessment of MSMs was conducted in 2004, injection drug users' HIV prevention needs were assessed in the spring of 2003, and a women at-risk assessment was completed in 2002. An assessment of the HRH population is now in the planning stages. Needs assessment results are provided first to the ICPC's Gap Analysis Committee and Prevention Intervention Committee, and then to the full ICPC as the studies are completed. ✓ A resource inventory of HIV prevention and care services was updated in early 2004, and was provided to the ICPC's Gap Analysis Committee and Prevention Intervention Committee, as well as the full ICPC. ✓ A gap analysis of prevention needs for Idaho's three priority populations was conducted in late May 2003, using the epi profile, needs assessment data, and resource inventory. This report was presented to the full ICPC in July 2003. A gap analysis of MSM prevention needs is currently being completed.

Objective E	Indicator
Ensure that prioritized target populations are based on an epidemiological profile and a community needs assessment.	✓ June 2004 Community Planning Membership Survey results indicate that 91 percent of ICPC members agreed that priority target populations were based on an epidemiologic profile and a community services needs assessment. 9 percent disagreed. ✓ At its July 2003 meeting, the ICPC used the following criteria to determine, rate, score and rank Idaho's priority populations: • AIDS Incidence • HIV Incidence • HIV/AIDS Mortality • HIV/AIDS Prevalence • Key indicators of risk behavior • Difficulty in meeting population needs • Barriers to reaching the population ✓ In prioritizing populations, the ICPC used the Epi Profile, needs assessments, resource inventory and gap analysis to determine scores and rankings.

Objective F	Indicator
Ensure that prevention activities and interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.	✓ June 2004 Community Planning Membership Survey results indicate that 91 percent of ICPC members agree that prevention interventions for each priority population are based on evidence of the following: a) behavioral and social science, b) effectiveness, c) cultural appropriateness, d) relevance, and e) acceptability. 8 percent disagreed. ✓ In selecting interventions, the ICPC used data available on current interventions, as well as Idaho's resource inventory and gap analysis, and national studies on proven interventions.

Goal Three
Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

Objective G	Indicator
Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Idaho STD/AIDS Program application for federal HIV prevention funding.	✓ 100 percent of the prevention interventions and supporting activities contained in the Idaho STD/AIDS Program's CDC funding application are specified as a priority in Idaho's 2004-2006 Comprehensive Prevention Plan. ✓ ICPC Co-Chair letters of concurrence with the plan and application are attached to this comprehensive plan.

Objective H	Indicator
Demonstrate a direct relationship between the Comprehensive Prevention Plan and funded interventions.	✓ 100 percent of the Idaho STD/AIDS Program's funded prevention interventions correspond to priorities specified in the 2004–2006 Comprehensive Plan.

LETTER OF CONCURRENCE

A Letter of Concurrence with Idaho's Comprehensive HIV Prevention Plan for 2004–2006 is attached from the ICPC Health Co-Chair, Jenny Ruppel, and Community Co-Chair, Mike Hirschi.

Insert Letter of Concurrence / Non-Concurrence

APPENDIX A

- ICPC Bylaws
- ICPC New Member Orientation Agenda
- ICPC Conflict of Interest Disclosure Form

Appendix A
Idaho HIV Care and Prevention Council Bylaws

Article 1. PURPOSE

The purpose of Idaho's Care and Prevention Council (ICPC) is to facilitate an ongoing statewide participatory process whereby the Idaho Department of Health & Welfare, STD/AIDS Program**,** shares responsibility with the ICPC for developing and implementing comprehensive plans for HIV/AIDS prevention and care. This statewide process is committed to engaging local communities in decision-making about HIV prevention and HIV/AIDS care, assuring that all affected communities are represented and involved in the process, and assuring that those who represent a specific community reflect that community's values, norms, and behaviors.

Article 2. NAMES, ROLES, AND RESPONSIBILITIES

The name of the statewide group is the Idaho HIV Care and Prevention Council, hereinafter referred to as the ICPC.

The role of the ICPC is to collaborate with the STD/AIDS Program and HIV/AIDS care providers to:

1) Assess the present and future extent, distribution, and impact of the HIV/AIDS epidemic in the state;
2) Assess existing community resources for HIV prevention and care services to determine the state's capacity to respond to the epidemic. These resources should be specific to HIV prevention and care programs and include fiscal, personnel, and program resources, as well as support from public (federal, state, county, and municipal), private, and volunteer sources;
3) Identify and prioritize at-risk populations based on current epidemiological data;
4) Identify unmet HIV prevention and care needs within the priority populations based on existing resources;
5) Use all existing and compiled data to identify strategies and interventions to deliver HIV prevention and care services to priority populations where identified;
6) Define the potential impact of strategies and interventions to prevent new HIV infections within the priority populations;
7) Prioritize HIV prevention strategies and interventions by priority population;
8) Develop statewide comprehensive HIV prevention and care plans;
9) Submit letters to the Centers for Disease Control and Prevention (CDC), written by the ICPC Co-Chairs, of concurrence or non-concurrence with the annual State of Idaho Comprehensive HIV Prevention Plan;
10) Evaluate the effectiveness of the HIV Prevention and Care Planning process throughout the state;
11) Assure compliance with CDC guidelines for HIV prevention community planning; and,
12) Assure compliance with HRSA guidelines for the development and implementation of a comprehensive plan for the delivery of HIV-related care services.

The role of the Idaho Department of Health & Welfare STD/AIDS Program**,** as the grantee for the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), is to:

1) Coordinate the HIV prevention and care planning process with a technical assistance provider;
2) Participate in the ICPC but not as Co-Chair. The STD/AIDS Program will have one member on the ICPC; other Program staff may provide technical assistance as needed;
3) Ensure the implementation of the HIV prevention and care planning process through a partnership with the ICPC;
4) Identify and assess needs for, and provide, technical assistance to the ICPC before, during, and after the HIV prevention and care planning process;
5) Coordinate the development of the statewide Epidemiological Profile and Needs Assessment for review by the ICPC;
6) Ensure compliance with CDC guidelines for HIV prevention community planning and HRSA requirements for the development and implementation of a comprehensive plan for delivery of HIV-related care services in Idaho.
7) Develop the applications for federal funds for HIV prevention and care services based on the Plan;
8) Ensure that an evaluation of the process is conducted with the ICPC to assure that problems and concerns may be addressed before the next year's process begins. A summary of the findings shall be mailed to all members of the ICPC and a copy kept on file for the next year's groups;
9) Ensure the implementation of the Plan; and,
10) Ensure that the CDC Guidance for Community Planning is adhered to with regard to use of expertise in behavior science by providing technical assistance from such experts when/as needed.

The shared role between the Idaho Department of Health & Welfare, STD/AIDS Program and the ICPC is to:

1) Develop policies and procedures that address provisions for making decisions, attendance at meetings, and resolution of conflict identified in planning deliberations;
2) Determine the distribution of planning funds to:

    a. convene the ICPC public meetings, and other means for obtaining community input;
    b. provide opportunities for the ICPC to obtain technical assistance and support from outside experts;
    c. provide resources that support the planning process, including the development, production, and distribution of the Plans; and,
    d. collect and/or analyze relevant data.

3) Determine distribution of HIV/AIDS care funds to provide necessary care services throughout the state;

4) Assess the present and future extent, distribution, and impact of the HIV/AIDS epidemic in the state;
5) Conduct a needs assessment process to identify unmet HIV prevention and care needs within the priority populations; and,
6) Develop, with technical assistance, Plans that reflect the ICPC's priorities, and meet the criteria established by the CDC, HRSA, and the STD/AIDS Program.

The role of each individual member of the ICPC is to:

1) make a commitment to the group's process and its results;
2) be prepared for and attend meetings;
3) undertake special tasks as requested by ICPC and agreed to by the member;
4) promote ICPC and its projects;
5) work to accomplish and support PIR within ICPC;
6) participate in all group discussions;
7) accept, endorse, and commit to the group's Roles and Responsibilities as adopted;
8) participate in process evaluation activities; and,
9) commit adequate personal and professional time to fulfill all of the above.

Regional groups may be constituted in various areas of the state under the general auspices of the ICPC. Such regional groups shall address issues of HIV/AIDS prevention and care in their region.

Article 3. MEMBERSHIP, GUIDANCE AND TERMINATION OF MEMBERS

The membership of the ICPC shall be consistent with the purposes and roles identified in Articles 1 and 2. The membership of the ICPC shall also reflect the criteria of PIR as described in the CDC Supplemental Guidance on HIV Prevention Community Planning to the extent that these criteria are compatible with the group's purpose and roles.

The size of the ICPC will not exceed 40 members. Each member exercises one vote.

The ICPC membership includes:

- Representation from the Idaho STD/AIDS Program.
- Representation from the seven district health departments, to be nominated by the Council of Family and Community Health Services (Physical Health Directors).
- Representation from populations at risk for HIV infection.
- Representation from populations infected with HIV.
- Representation from State or local education agencies.
- Representation from Governmental corrections, substance abuse and/or mental health agencies.
- Epidemiology experts.
- Behavioral or social health science experts.
- Program evaluation experts.
- Health planning experts.

- Representation from key organizations providing HIV prevention, care, and related services (including Ryan White Care Consortia, Ryan White Title III grantees, organizations providing housing services for HIV/AIDS clients, and regional care and prevention groups).
- Representation from other key non-governmental organizations relevant to HIV prevention and care.

All prospective members must make written application to the Administrative Committee, which will conduct an open nomination process and review applications annually. The Administrative Committee will make its new member recommendations to the Executive Committee for final approval.

The terms of ICPC members will be three (3) years. ICPC members will have staggered terms, with approximately one-third of the members' terms expiring at the end of each year. Terms of members whose membership is due to expire may be renewed upon the request of the member through a written renewal application, recommendation of the Administrative Committee, and approval of the Executive Committee. New terms will begin on January 1st of each year.

If an ICPC member resigns from the ICPC before his or her term expires, the Administrative Committee will consider nominations to fill representation for the organization, population or expertise the individual represented, if such representation is needed by the current make-up of the ICPC. The Administrative Committee will determine whether a vacancy shall be filled immediately, or be filled through the annual new application process.

If an individual becomes a member of the ICPC representing a specific membership category and that status changes partway through his/her term, the member may make a written request to the Administrative Committee to continue as an ICPC member, and a potential new member from the membership category originally represented may be recruited by the Administrative Committee to serve on the ICPC. The Administrative Committee will consider the size of the ICPC and PIR in reviewing the original member's request to remain on the ICPC, and in recruiting any potential replacement member.

Attendance of ICPC members is required at all ICPC meetings and in all committee functions (face-to-face meetings, conference calls, etc). A member sign-in sheet shall be used at all meetings to determine and document attendance. These sheets will be attached to each meeting's minutes for verifications. Minutes shall be taken during all committee functions, with attendance recorded. Committee minutes will be submitted to the Community Prevention Planning technical assistance provider. If a member does not attend an ICPC meeting or is not involved in committee functions, the Co-Chairs will notify the Administrative Committee for action. The Administrative Committee will contact the absent member to determine the reason for absence. If there is no good cause for absence, or if there is a pattern of continued absences even with good cause, the Administrative Committee will then discuss with the member his or her continued commitment to the ICPC and whether membership should be continued. The Administrative Committee will have the ability to terminate an individual's membership for attendance reasons if deemed appropriate by Committee members. The Administrative Committee will inform the ICPC of its findings and actions, excluding any personal confidential information.

In addition to attendance issues, memberships may also be terminated as follows:

1) Submission of a resignation letter by the member.
2) For good cause as determined by the ICPC membership.
3) By the recommendation of a regional group to the Administrative Committee, if the member was nominated by that regional group.
4) Expiration of membership term with no member request or Executive Committee approval for renewal.

Article 4. OFFICERS ROLES AND RESPONSIBILITIES

Officers of the ICPC shall consist of two Co-Chairs and a Secretary. One Co-Chair must be a local Health Department representative and the other must be a community representative. A prospective Co-Chair must have served for a minimum of one year as an ICPC member before being eligible to be considered for election as a Co-Chair. The ICPC will strive to select Co-Chairs with geographical and gender balance. The Secretary may be a paid staff person of the STD/AIDS Program or Community Planning technical assistance provider.

The terms of the ICPC Co-Chairs will be two (2) years with one Co-Chair being elected each June and taking office the following January. Co-Chairs may stand for re-election. If the Executive Committee believes that a Co-Chair is not fulfilling the duties of his/her office, the Executive Committee will meet with the Co-Chair to discuss the situation, and then take appropriate action as needed on that individual's office and/or membership.

The role of the Co-Chairs is to:

1) share responsibility in guiding the ICPC in accomplishing its purpose;
2) help prepare agendas and conduct meetings;
3) oversee, with the STD/AIDS Program, the distribution and use of funds to support community planning meetings;
4) communicate with the STD/AIDS Program regarding HIV prevention and care services planning;
5) participate with the STD/AIDS Program in developing policy regarding HIV prevention and care services planning;
6) represent the ICPC and HIV prevention and care services planning in their local communities;
7) represent the ICPC membership at meetings with the STD/AIDS Program staff;
8) write a letter of concurrence or non-concurrence on behalf of the ICPC to accompany the HIV Prevention Plan and cooperative agreement to CDC; and,
9) review the Care Services plan on behalf of the ICPC.

The role of the Secretary is to:

1) take minutes of the meetings;

2) send out the agenda, minutes of the previous meeting, and the meeting schedules prior to the next ICPC meeting;
3) keep and file copies of all agendas, minutes, ICPC membership lists, bylaws and ICPC member Disclosure Statements;
4) make meeting room and refreshments arrangements; and,
5) other duties, as needed.

The role of committee chairs is to:

1) take responsibility for guiding the committee in accomplishing its purpose;
2) prepare and distribute to all committee members agendas for committee meetings and conference calls;
3) submit, in a timely manner, copies of agendas and minutes for all committee meetings and conference calls to the Secretary;
4) provide input to the ICPC Administrative Committee regarding activity and functioning of each committee member; and,
5) serve as a member of the ICPC Executive Committee.

Article 5. GOVERNANCE OF MEETINGS

All ICPC meetings shall be open to the public, however, open forums for discussion must be approved by the ICPC Co-Chairs. Interested parties must submit to the Co-Chairs a written outline or summary of issues they recommend for inclusion on the meeting agenda at least seven (7) working days before the ICPC meeting.

The decisions of the ICPC shall be made by consensus whenever possible. Should ICPC members fail to reach a consensus within a reasonable amount of time as determined by the presiding Co-Chairs, a simple majority vote of all voting members present and proxies may be called.

ICPC meetings may be conducted by a meeting facilitator.

Each voting member may designate a proxy. A proxy vote shall be delivered only by another voting member of the ICPC. A written verification designating the proxy from the absent voting member must be produced prior to any vote taken.

The Co-Chairs and/or a majority of the ICPC membership may establish ad hoc committees and work groups as identified and needed. Committee Chairs will report to the Executive Committee as appropriate. The following will be standing committees meeting only as necessary:

1) Administrative Committee
2) Care Services Committee
3) Executive Committee
4) Gap Analysis Committee
5) Needs Assessment Committee
6) Prevention Interventions Committee

7) Resource Inventory Committee

As new members of the ICPC begin their service, they will indicate in writing three (3) of the above committees on which they would be willing to serve. The Executive Committee, taking into consideration needs of the ICPC, will assign each member to one (1) committee. Any grievance regarding committee assignment or responsibilities, or other issues relating to committee service, shall be directed in writing to the Co-Chairs, who will handle the matter in accordance with the ICPC Grievance Procedure.

Chairs of the standing committees will be selected by the Executive Committee. The terms of committee chairs shall be two (2) years. As individual chair's terms expire, all members of the committee will be asked to indicate in writing their willingness to serve as chair of the committee. Those who are willing to serve will be reviewed by the Executive Committee and a chair selection will be made. Chairs may succeed themselves.

The Administrative Committee shall:

1) prepare and maintain a list of all ICPC members for the record. This list and updated lists will be distributed to all members and a copy kept by the ICPC Secretary;
2) establish and maintain an open membership nomination and recruitment process in keeping with CDC, HRSA, and STD/AIDS Program guidance;
3) recruit and nominate new members for approval or rejection by the Executive Committee, with newly approved members to begin serving each January. The Executive Committee will make their decision and pass along recommendations for approval by the state STD/AIDS Program;
4) review renewal applications of members whose terms are expiring, and make renewal recommendations to the Executive Committee;
5) follow-up on absentee members, and terminate a person's membership if needed according to the provisions of Article 3;
6) recommend to the ICPC membership policies and procedures regarding other membership issues;
7) evaluate the planning process for ICPC; and,
8) review evaluations of ICPC meetings and recommend changes in protocols/procedures as necessary to improve efficiency and efficacy of meetings.

The Care Services Committee shall:

1) recommend solutions to address gaps and barriers to care identified by the gap analysis;
2) identify long and short-term goals;
3) develop a description of existing continuum of care; and,
4) assist in developing the state's services delivery plan.

The Executive Committee shall:

1) consist of the two Co-Chairs, the representative from the STD/AIDS Program and the chairs of the standing committees;

2) be empowered by the ICPC to work with the STD/AIDS Program to make decisions about time-critical issues between scheduled ICPC meetings;
3) review the Plans before their submission to CDC or HRSA; however, only the ICPC Co-Chairs have the authority to write letters of concurrence or non-concurrence to CDC;-
4) review interventions for care and prevention issues as submitted by the Care Services Committee and the Prevention Interventions Committee and forward them to the STD/AIDS Program;
5) annually review the epidemiological profile and all other relevant data to determine priority populations to be addressed in prevention efforts, and present those priority population recommendations to the ICPC;
6) handle conflict of interest issues as follows:
    a. Conduct a prompt and complete review of all potential conflicts of interest and other disputes brought before the Executive Committee by any member of the ICPC;
    b. Ensure the Conflict of Interest Disclosure Statement is completed by all members of the ICPC; and,
    c. Recommend, for the ICPC's approval, a review process based on the following principles of dispute resolution:
        - Establish a goal that includes the concerns of all involved.
        - Maintain a climate of fairness and mutual respect.
        - Distinguish between the person and the problem.
        - Identify and build upon areas of agreement.
        - Distinguish between interests and positions.
        - Develop options for mutual gain.
        - Use objective criteria.
    d. When the conflict of interest pertains to an Executive Committee member, that member will take part in discussions relating to issues associated with the conflict only to the extent of answering questions about those issues and will not take part in any votes relating to those issues.

7) There is no limit on the number of terms an Executive Committee member may serve.

The Gap Analysis Committee shall:

1) analyze the data produced by the Needs Assessment and Resource Inventory Committees to determine gaps and barriers to successful prevention and care in the state of Idaho; and,
2) recommend measures by which gaps and barriers might be overcome.

The Needs Assessment Committee shall:

1) assess the prevention and care needs of Idaho's at-risk populations, using all appropriate data, both epidemiological and otherwise; and,
2) consult with experts in behavioral science and evaluation in developing and reviewing all analyses.

The Prevention Interventions Committee shall:

1) use data from the gap analysis, various needs assessments and the epidemiological profile to research and recommend prevention interventions to meet identified gaps targeting specific priority populations;
2) review the current statewide prevention intervention strategy and evaluate the need for continuation of existing intervention; and,
3) review new prevention intervention program options and make recommendations concerning promising intervention activities that address identified gaps in the State's comprehensive prevention intervention strategy.

The Resources Inventory Committee shall:

1) conduct thorough inventories of community resources available for both prevention and care throughout the state, the inventories to include providers' capacity and capability to provide related prevention and/or care services.

Article 6. CONFLICT OF INTEREST

The ICPC may have members who are professionally or personally affiliated with organizations that have or may request or receive funds from the STD/AIDS Program for HIV prevention activities. Because of the potential for conflict of interest, the ICPC has adopted the attached Disclosure Statement which all current and future ICPC members must complete and provide to the ICPC to be kept by the Secretary.

The reputation and credibility of the ICPC rests on its ability to make fair, objective, and impartial decisions. Accordingly, it is essential to avoid situations where a conflict of interest may influence, or appear to influence, the decision-making process. There are two types of conflict of interest situations:

1) Where a member or relative or partner etc. has a financial interest, or appears to have a financial interest, in the outcome of a decision by the ICPC; and,
2) Where a member has an affiliation or other conflict of loyalties that may lead to or suggest influence over the outcome of a decision by the ICPC.

The following guidelines are intended to help the ICPC avoid both types of conflict.

GENERAL
From time to time, an ICPC member may serve as an officer, staff member, director, trustee, active volunteer or consultant to an organization with a vested interest in the outcome of the decision making process of the ICPC. Situations may arise where a member's business or personal interests may be affected by the outcome of a decision by the ICPC. In all such cases, the potential for conflict should be recognized and disclosed, and appropriate steps taken to prevent influence or favoritism by such members in the decision-making process.

DISCLOSURE
At the first ICPC meeting of the calendar year, each ICPC member is under obligation to the ICPC and its members to disclose any position in which they and/or household member and/or

blood relative serve or have served in a staff, consultant, officer, board member, advisor capacity, or volunteer and the investment in any business over the past twelve (12) months that may result in a possible conflict of interest with organizations that receive, may seek and/or are eligible for HIV prevention and/or care services funding within the scope of ICPC influence. A member should also disclose any activity or interest that may cause bias for or against a particular action or policy being considered by the ICPC.

Each ICPC member is asked to file a Disclosure Statement annually. All Disclosure Statements will be circulated for review by ICPC members.

Any ICPC member, upon recognizing a potential conflict of interest, may excuse her/himself from all discussion, debate or vote for which a conflict of interest exists. Any ICPC member who perceives a potential conflict of interest in another member should first approach that member regarding the concerns. Such, approaches should be presented and interpreted by all members as a concern for the integrity of the decisions of the ICPC and not as a personal attack. If a successful resolution cannot be reached, the ICPC may initiate a review by the Executive Committee, by making a verbal request for review or by presenting the concerns in writing. The Executive Committee will adjourn briefly during a meeting in which an unresolved conflict of interest matter was raised to conclude the matter. Executive Committee members will excuse themselves from participating in a review of disputes when they are too close to the conflict or involved parties. Decisions of the Executive Committee may be appealed in writing to the ICPC Co-Chairs one time. Co-Chairs' unanimous decisions are final.

To maintain the Council's awareness of the importance of conflict of interest considerations, each meeting of the ICPC will begin with member introductions and the mention of conflict of interest. Part of the introduction will include a discussion of the members' affiliations where conflict of interest is a potential issue, particularly those affiliations which could be affected by ICPC decisions.

Article 7. AMENDMENTS TO BYLAWS

1) Amendments to these Bylaws may be proposed by;
    a. A majority of the Executive Committee; or,
    b. A petition signed by no less than ten percent (10%) of the ICPC membership.
2) Proposed amendments shall be mailed to each ICPC member not less than thirty (30) days prior to the meeting at which they are to be considered.
3) An amendment shall become effective only upon approval by two-thirds (2/3) of the ICPC members present at the meeting at which the amendment is considered.

The undersigned Secretary of the Idaho Care and Prevention Council (ICPC) does hereby certify that the above Bylaws were duly adopted by the ICPC.

DATED this _____ day of _____ 20__

By:_____
Secretary

Sample ICPC New Member Orientation Agenda

7:00 p.m. Welcome and Introductions
ICPC Co-Chairs

7:15 p.m. Why Are We Here? An overview of Community Planning
Idaho STD/AIDS Program Manager

- What is community planning (CP)
- History of CP
- Governance of CP
- Process of community planning

8:15 p.m. Overview of the Idaho HIV Care and Prevention Council
ICPC Co-Chairs

- ICPC role: assess needs, set priorities, review state plan, evaluate prevention efforts
- Role of Co-chairs
- ICPC membership- terms, PIR, who's at the table
- ICPC committees: What they and are what they do
- Member expectations: ICPC meetings and committee work
- ICPC support by STD/AIDS Program, technical assistance providers, facilitator, CDC
- Where we are in the community planning process?
- New member mentoring by the ICPC Executive Committee

8:45 p.m. Open discussion / Q & A

9:00 p.m. Adjourn

Idaho HIV Care and Prevention Council
Conflict of Interest Disclosure Statement

I have been involved with the following organizations in the past twelve (12) months that may present a possible conflict of interest with decisions that are made by the ICPC.

Organization: _____

Title/Role in Organization: _____

Period of Affiliation: _____

Organization: _____

Title/Role in Organization: _____

Period of Affiliation: _____

Organization: _____

Title/Role in Organization: _____

Period of Affiliation: _____

Other affiliations which may cause bias:

(please attach additional pages if necessary)

Any ICPC member, upon recognizing a potential conflict of interest, may excuse her/himself from all discussion, debate or vote for which a conflict of interest exists.

I understand and will comply with the ICPC Conflict of Interest Disclosure Statement.

_____ _____
Signature of ICPC Member *Date*

APPENDIX B

Community Planning Membership Survey Report

HIV Prevention Community Planning Membership Survey Report

Name of the jurisdiction your CPG represents: State of Idaho

Name of the CPG: Idaho HIV Care and Prevention Council

Type of CPG: Statewide

How many months is one term on the CPG for members: Three years

Part A – Community Planning Group Membership Profile

Table 1: Age

<19	20-24	25-29	30-49	50+	Unknown	Total CPG Members
0	1	3	13	7	0	24

Table 2: Gender

Male	Female	Transgender	Unknown	Total CPG Members
10	14	0	0	24

Table 3a: Race						
American Indian or Alaska Native	**Asian**	**Black or African American**	**Native Hawaiian/Other Pacific Islander**	**White**	**Unknown**	**Total CPG Members**
0	0	3	0	21	0	24

Table 3b: Ethnicity			
Hispanic or Latino	**Not Hispanic or Latino**	**Unknown**	**Total CPG Members**
1	23	0	24

Table 4: Geographic Distribution				
Urban Metropolitan Area	**Urban Non-Metropolitan Area**	**Rural Area**	**Unknown**	**Total CPG Members**
6	17	1	0	24

Table 5a: Primary Area of Expertise								
Epidemiologist	**Behavioral or Social Scientist**	**Evaluation Researcher**	**Intervention Specialist**	**Health Planner**	**Community Representative**	**Other***	**Unknown**	**Total CPG Members**
0	2	1	0	3	8	10	0	24

* Other includes state/local education agency, higher education, and HIV prevention and care service providers.

Table 5b: Secondary Area of Expertise								
Epidemiologist	**Behavioral or Social Scientist**	**Evaluation Researcher**	**Intervention Specialist**	**Health Planner**	**Community Representative**	**Other***	**Unknown**	**Total CPG Members**
0	0	0	2	0	2	0	0	4

Table 6: HIV Risk Category						
MSM	**MSM/IDU**	**IDU**	**Heterosexual**	**Mother with or at risk for HIV infection**	**None**	**Total CPG Members**
6	0	1	2	0	15	24

Table 7a: HIV Risk Category by Ethnicity							
Category / Ethnicity	**MSM**	**MSM/IDU**	**IDU**	**Heterosexual**	**Mother with or at risk for HIV infection**	**General Public**	**Unknown**
Hispanic or Latino	1	0	0	0	0	0	0
Not Hispanic or Latino	5	0	1	2	0	15	0
Unknown	0	0	0	0	0	0	0
Subtotal CPG Members	6	0	1	2	0	15	0

Table 7b: HIV Risk Category by Race							
Category / Race	MSM	MSM/IDU	IDU	Heterosexual	Mother with or at risk for HIV infection	General Public	Unknown
American Indian or Alaska Native	0	0	0	0	0	0	0
Asian	0	0	0	0	0	0	0
Black or African American	1	0	0	0	0	2	0
Native Hawaiian/Pacific Islander	0	0	0	0	0	0	0
White	5	0	1	2	0	13	0
More Than One Race	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0
Subtotal CPG Members	6	0	1	2	0	15	0

Table 8a: CPG Members Living With HIVAIDS			
Yes	**No**	**Unknown**	**Total CPG Members**
4	20	0	24

Table 8b: CPG Members Not Living With HIVAIDS but Affected by HIV/AIDS			
Yes	**No**	**Unknown**	**Total CPG Members**
7	17	0	24

Table 9a: Primary Agency/Other Representation												
Faith Community	**Minority Board CBO**	**Non-Minority Board CBO**	**Other Nonprofit**	**State Health Dept.**	**Local Health Dept.**	**Other Gov't**	**Academic Institution**	**Research Center**	**Indiv'l**	**Other**	**Unknown**	**Total CPG Members**
	1	0	5	1	5	1	2	0	9	0	0	24

Table 9b: Secondary Agency/Other Representation												
Faith Community	**Minority Board CBO**	**Non-Minority Board CBO**	**Other Nonprofit**	**State Health Dept.**	**Local Health Dept.**	**Other Gov't**	**Academic Institution**	**Research Center**	**Indiv'l**	**Other**	**Unknown**	**Total CPG Members**
			2						1			3

Part B – Community Planning Membership Survey

Objective A: Implement an open recruitment process (outreach, nomination and selection) for CPG membership.			
Column A	**Column B**	**Column C**	**Column D**
Total Number of "Agree" Responses to Items in "Objective A"	Total Number of "Disagree" Responses to Items in "Objective A"	Total Number of "Agree" and "Disagree" Responses to Items in "Objective A." This number represents the Total Number of Valid Responses.	Percentage Agreement for Items in "Objective A"
107	4	111	96%

Objective B: Ensure that the CPG's membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the state, and includes key professional expertise and representation from key governmental and non-governmental agencies.			
Column A	**Column B**	**Column C**	**Column D**
Total Number of "Agree" Responses to Items in "Objective B"	Total Number of "Disagree" Responses to Items in "Objective B"	Total Number of "Agree" and "Disagree" Responses to Items in "Objective B." This number represents the Total Number of Valid Responses.	Percentage Agreement for Items in "Objective B"
51	1	52	98%

Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.			
Column A	**Column B**	**Column C**	**Column D**
Total Number of "Agree" Responses to Items in "Objective C"	Total Number of "Disagree" Responses to Items in "Objective C"	Total Number of "Agree" and "Disagree" Responses to Items in "Objective C." This number represents the Total Number of Valid Responses.	Percentage Agreement for Items in "Objective C"
85	8	93	91%

Objective D: Carry out a logical, evidence-based process to determine the highest priority, population specific prevention needs in the state.			
Column A	**Column B**	**Column C**	**Column D**
Total Number of "Agree" Responses to Items in "Objective D"	Total Number of "Disagree" Responses to Items in "Objective D"	Total Number of "Agree" and "Disagree" Responses to Items in "Objective D." This number represents the Total Number of Valid Responses.	Percentage Agreement for Items in "Objective D"
226	43	269	84%

Comment: The majority of "disagree answers" concerned the specifics of the gap analysis. The latest gap analysis presented to the ICPC did not meet all of the CDC Guidance Indicators. The ICPC Gap Analysis Committee is currently revising its gap analysis report to better reference the data used, specify both met and unmet needs, and identify the portion of needs being met with CDC funds. This will be presented to the ICPC in the fall of 2004, and included in Idaho's 2006 Plan update.

Objective E: Ensure that prioritized target populations are based on an epidemiological profile and a community needs assessment.			
Column A	**Column B**	**Column C**	**Column D**
Total Number of "Agree" Responses to Items in "Objective E"	Total Number of "Disagree" Responses to Items in "Objective E"	Total Number of "Agree" and "Disagree" Responses to Items in "Objective E." This number represents the Total Number of Valid Responses.	Percentage Agreement for Items in "Objective E"
75	7	82	91%

Objective F: Ensure that prevention activities and interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.			
Column A	**Column B**	**Column C**	**Column D**
Total Number of "Agree" Responses to Items in "Objective F"	Total Number of "Disagree" Responses to Items in "Objective F"	Total Number of "Agree" and "Disagree" Responses to Items in "Objective F." This number represents the Total Number of Valid Responses.	Percentage Agreement for Items in "Objective F"
74	7	81	91%

Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Idaho STD/AIDS Program application for federal HIV prevention funding. **Objective H: Demonstrate a direct relationship between the Comprehensive Prevention Plan and funded interventions.**			
Column A	**Column B**	**Column C**	**Column D**
Total Number of "Agree" Responses to Items in "Objective G"	Total Number of "Disagree" Responses to Items in "Objective G"	Total Number of "Agree" and "Disagree" Responses to Items in "Objective G." This number represents the Total Number of Valid Responses.	Percentage Agreement for Items in "Objective G"
43	3	46	93%

Overall Percentage of Agreement			
Column A	**Column B**	**Column C**	**Column D**
Total Number of "Agree" Responses to Items in "Objective H"	Total Number of "Disagree" Responses to Items in "Objective H"	Total Number of "Agree" and "Disagree" Responses to Items in "Objective H." This number represents the Total Number of Valid Responses.	Percentage Agreement for Items in "Objective H"
661	73	734	90%

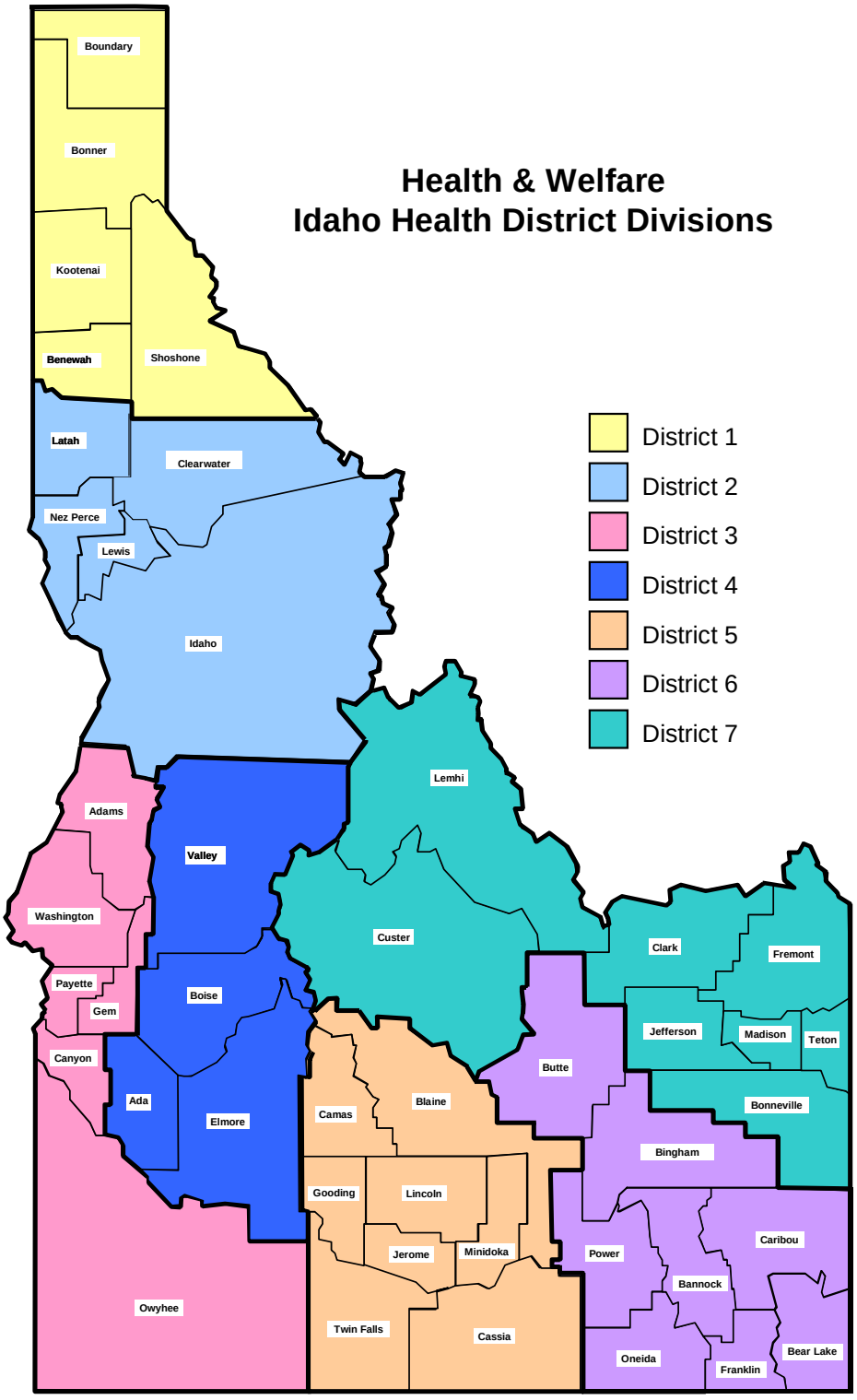
Date Report was Completed: <u>June 25, 2004</u>

_____ Community Co-Chair Signature

_____ Health Department Co-Chair Signature

APPENDIX C

Map of Idaho's Seven Health Districts



APPENDIX D

Epidemiologic Profile of HIV/AIDS in Idaho